MIDTERM EVALUATION OF USAID/ECUADOR'S CHILD SURVIVAL AND HEALTH PROJECT

POPTECH Project Number 97-121-058
April 1998

by

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Prepared for

U.S. Agency for International Development
Bureau for Global Programs
Office of Population
Contract No. CCP-3024-Q-00-3012
Project No. 936-3024

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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APPENDICES

LIST OF ABBREVIATIONS

APOLO	*Proyecto de Apoyo a Organizaciones Locales*/Support to Local Organizations project
ARI	Acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival project
CEMOPLAF	*Centro Medico de Orientación y Planificación Familiar*/Medical Center of Orientation and Family Planning
CARE	Cooperative for Assistance and Relief Everywhere
CEP	*Comité Ejecutivo del Proyecto/*Project Executive Committee
CHS	Center for Human Services
CEPAR	*Centro de Estudios de Población y Paternidad Responsable*/Center for Population and Family Planning Studies
CIAR	*Comité Interagencial de Apoyo a la Reforma*/Council for Inter-Agency Reform
CONAM	*Consejo Nacional de Modernización*/National Modernization Council
CONASA	*Consejo Nacional de Salud*/National Health Council
CS	Child survival
DALY	Disability-adjusted life years
EOPS	End of project status
EPI	Expanded Programme on Immunization
ENDEMAIN	*Encuesta Demográfica y de Materno-Infantil Nacional/*National Demographic Survey of Mothers and Children
ESPOL	*Escuela Politecnica del Litoral/*Polytechnic School of the Coast
FASBASE	*Proyecto Fortalecimiento y Ampliación de los Servicios Basicos de Salud en Ecuador/*Project for the Strengthening and Expansion of Basic Health Services in Ecuador
FECD	*Fundo Ecuatoriano Canadiense de Desarrollo/*Ecuadorian-Canadian Fund for Development
GOE	Government of Ecuador
IDB	InterAmerican Development Bank
IESS	*Instituto Ecuadoriano de Seguridad Social/*Ecuadorian Institute of Social Security
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant mortality rate
INEC	*Instituto Nacional de Estadística y Censos*/National Statistics Institute
M&E	Monitoring and Evaluation System
MCH	Maternal/child health
MOH	Ministry of Health
MODERSA	*Proyecto de Modernización de Salud*/Health Modernization Project
MTE	Midterm evaluation
NGO	Non-governmental organization
OMNI	Opportunities for Micronutrient Interventions project
PAHO	Pan American Health Organization
PACD	Project assistance completion date

PAPPS	*Proyecto Análisis y Promoción de Políticas de Salud/* Analysis and Promotion of Health Policies Project
PHC	Primary health care
PHR	Partnerships for Health Reform project
PNMC	*Programa Nacional de Mejoramiento de Calidad*/National Program for Quality Improvement
QA	Quality Assurance project
RFS	Rapid Feasibility Study
RPM	Rational Pharmaceutical Management project
SO	Strategic Objective
TAACS	Technical Advisors in AIDS and Child Survival
TAG	Technical Advisory Group
UNFPA	*Fundo de las Naciones Unidas para Actividades de Población/* United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
URC	University Research Corporation
URMES	*Uso Racional de Medicamentos en Escuelas Saludable/*USAID's Rational Use of Drugs in Health Schools program
USAID	United States Agency for International Development
WHO	World Health Organization

PROJECT IDENTIFICATION DATA

1.	**Project Title:**	Health and Child Survival
2.	**Country:**	Ecuador
3.	**Project Number:**	518-0071
4.	**Project Dates:**	
	Agreement Signed:	July 14, 1989
	End Date:	September 30, 2000
5.	**Project Funding:**	
	Authorized Life-of-Project Funding:	$18,000,000
	Funding to Date:	$16,177,000
	Host Country Funding:	$16,930,000
6.	**Mode of Implementation**:	Bilateral Agreement with the Ministry of Health and Cooperative Agreements with CARE and CEPAR
7.	**Responsible USAID Officials**:	
	Mission Director:	Thomas L. Geiger
	Director, General Development Office:	Kenneth Farr
	Project Officer:	Jack Galloway
8.	**Previous Evaluation(s):**	August 1993 (John Snow, Inc.)

EXECUTIVE SUMMARY

The U.S. Agency for International Development (USAID) strives to improve the health of infants, children, and mothers in Ecuador through its Child Survival and Health Project (518-0071). This project contributes to USAID/Ecuador's (USAID/E) *Strategic Objective 2: Increased use of sustainable family planning and maternal/child health services*, and includes two *Intermediate Results: Improved Quality and Access of MCH Services (IR3) and Increased Sustainability of Health NGOs (IR4)*.

USAID/E began supporting child survival (CS) activities and the Ministry of Health (MOH) in 1985. After ten years, evaluations revealed that progress was slow and overall achievements were unsatisfactory; thus, in 1995 USAID/E completely redesigned the project. The new approach, called Phase 2 or "Amendment 8," focused on health sector reform, and for the first time, included two non-governmental organizations (NGO), the Cooperative for Assistance and Relief Everywhere (CARE) and the Center for Population and Family Planning Studies (*Centro de Estudios de Población y Paternidad Responsable* [CEPAR]). The bold mandate for these NGOs did not require close collaboration with the MOH and in fact, USAID's project design encouraged one NGO to work almost independently of the MOH altogether. Phase 2's shift from a purely public sector activity with the MOH to a somewhat compartmentalized approach with distinct public (MOH) and private sector (NGO) partners has significantly "widened the playing field" for USAID/E. It has also put USAID/E in the difficult but self-chosen position of having to coordinate activities among project "partners" who may not feel like peers in the overall endeavor. As a result, Phase 2 has confronted new challenges and new constraints but it has also realized greater accomplishments than would have been possible in the previous design.

At the request of USAID/E, POPTECH conducted a midterm evaluation of the Child Survival and Health project from October 19 to November 7, 1997. POPTECH's evaluation team reviewed project progress and made recommendations that could be used to make adjustments in the administration of the activities planned for the final two to three years of the project. The external evaluation team and their specialties are as follows: Dr. Carlos Cuellar, health services management; Dr. Eduardo Navas, public health services planning; Mr. Hugh Waters, health financing; and team leader Dr. Mary Ruth Horner, maternal/child health (MCH) program design and evaluation. Information that contributed to the team's discussions was derived from reviewing documents, interviewing key informants, and conducting site visits to Cuenca (Azuay), Imbabura, Guayaquil, and Santa Elena (Guayas).

USAID/E is currently in a "phaseout" mode, a fear that became reality only a few months before the midterm evaluation (MTE). For the most part, this phaseout has heightened the sense of urgency among USAID/E's CS project staff and their partners. Unfortunately, "urgency" is not a term often associated with the typical pace of reform and health sector reform is no exception. Therefore, USAID/E's task is now doubly formidable: (1) to bring about health sector reforms as originally planned by the end of Phase 2 and (2) to leave its public and private sector partners capable of continuing the reform process without USAID/E's assistance beyond the year 2000.

Phase 2 of the CS project has been operating in an extremely volatile political context. Since the project's 1995 start date, Ecuador has had three presidents and all the turnover, paralysis, and turmoil that inevitably accompany governmental change. The current interim government has been in power since February 1997 and will be replaced by a newly elected government in August 1998.

Once the CS project was redesigned and Phase 2 began in 1995, USAID/E moved into new territory in an attempt to draw attention to, gain practical experience with, and accelerate health reform in Ecuador. These efforts were implemented particularly through private sector models. The concept of reform itself brings to mind different concepts and images for each individual; USAID/E is endeavoring to give definition to some of these critical concepts and develop them into a positive reality for health care producers, providers, and consumers. Much has happened in the short time since Phase 2 began. This is summarized in the following section by the three major project components:

1. **CARE**: Private sector program strengthening
2. **CEPAR**: Policy analysis and promotion
3. **Ministry of Health**: Policy reform

CARE

CARE's role in Phase 2 is through its Support to Local Organizations project (*Proyecto de Apoyo a Organizaciones Locales* [APOLO]), whose goal is to develop the capacity of private sector institutions and municipalities to provide sustainable CS and primary health care (PHC) services. APOLO has worked with these private sector partners in eight provinces to develop 10 demonstration projects. Through subgrants and technical assistance, APOLO is assisting each of its chosen partners to integrate new features into their operations, that is, to expand services and coverage, develop a network of health services, decentralize services under control of the municipality, integrate traditional and Western medicine, and cross-subsidize services.

The MTE team visited four of APOLO's ten demonstration projects: Fundación Pablo Jaramillo, Cuenca (cross-subsidization); Chordeleg, Azuay (decentralization); Medical Center of Orientation and Family Planning *(Centro Medico de Orientación y Planificación Familiar* [CEMOPLAF])/Otavalo (expanded services); and Santa Elena (creation of a network). The team obtained broader information about the overall project by reviewing documents and meeting with APOLO staff and others familiar with APOLO's work.

APOLO's Major Accomplishments

The APOLO staff are generally regarded as very competent, creative, and dedicated to their mission. In turn, the APOLO-supported NGOs have increased their potential to participate in activities directly by having become more efficient and sustainable health providers, and indirectly by having developed the potential to be replicated. As a result of this NGO development, there has been (1) a steady increase in demand for family planning and new pediatric services and plans

already developed for replication of the new CEMOPLAF/Otavalo model to other CEMOPLAF clinics, (2) a steady increase in cost recovery for health services provided by Fundación Pablo Jaramillo due to a more streamlined financial system that permits cross-subsidization of services, and (3) increases in coverage by the church-run clinics in Chordeleg and Santa Elena. In addition, CARE has successfully leveraged USAID/E's funds by incorporating two international organizations as additional donors and supporters.

Of those projects visited, the Santa Elena project appears to have the most potential for impact because it has successfully integrated the three critical elements that determine capacity for participating in reform: NGO, municipal government, and MOH. The results of the Fundación Pablo Jaramillo and CEMOPLAF/Otavalo projects are also important for reform, but both sites are limited by their unique technical and management contexts.

Operational coordination with the MOH has proven exceedingly difficult, especially in situations that require the transfer of MOH facilities to another entity—a community board or municipal committee—to effect reform. Coordination is easier in the case of demonstration projects whose implementation does not directly depend upon the MOH (all of those visited except Chordeleg).

The team concluded that APOLO's demonstration projects are not models per se, rather they constitute partial elements of a potential single model for health service provision. As APOLO is currently implemented, it is providing successful experiences that can be incorporated into existing organizations. However, for the MOH to give appropriate attention to APOLO's global importance, these individual successes must be viewed within a larger integrated reform context, not as isolated experiences.

In its drive to implement APOLO and produce results, CARE has developed an isolationist image among other health sector professionals, such as staff of the MOH, municipalities, and NGOs. This perception has prevented the representatives of some of these organizations from being able to collaborate with APOLO as they believe would be mutually beneficial.

CEPAR

CEPAR, the second major NGO component of USAID/E's Phase 2, is an Ecuadorian NGO that had its beginning in the family planning field. In May 1995, CEPAR and USAID signed a Cooperative Agreement creating the Analysis and Promotion of Health Policies Project (*Proyecto Análisis y Promoción de Políticas de Salud* [PAPPS]). Through PAPPS, CEPAR is responsible for developing and implementing activities to build a broad-based consensus among Ecuadorian leaders and interest groups for health reform and modernization. In addition, CEPAR conducts and disseminates analyses and studies on health policy reforms to encourage and promote a greater public dialogue on the need to modernize health sector institutions and delivery systems. CEPAR is applying these principles on a pilot basis in two provinces and three *cantóns* (counties).

CEPAR's Major Accomplishments

Similar to APOLO, the CEPAR staff participating in Phase 2 are highly regarded for their professionalism, dedication, and motivation. Through the wide range of health reform activities being implemented in Phase 2, CEPAR has achieved a reputation for technically sound analysis. In addition, it has gained a high profile in Ecuador's health sector, which is all the more notable for an organization that is not involved in actually providing health services.

Some of CEPAR's major accomplishments are (1) playing a critical role in supporting the efforts of the National Health Council (*Consejo Nacional de Salud* [CONASA]) to promote health reform; (2) organizing and implementing 25 seminars and workshops on health reform; (3) assisting the Congressional Health Commission in formulating, reviewing, and promoting laws that support health reform, such as the recent law to ensure financing for child vaccines; (4) energizing and supporting two forums of NGO representatives so that NGOs have a recognized place in the health reform debate; (5) assisting the municipality of Cotacachi, Imbabura, to develop systems for decentralizing health services and by doing so, creating a model for other municipalities that are facing the same challenge; and (6) assisting health leaders in several provinces to develop provincial health plans in conjunction with the decentralization process.

Such diversity of activities is necessary to reach a wide variety of audiences; however, it can be overwhelming and result in a lack of focus and an overextended staff. Indeed, CEPAR may become the victim of its own success by running the risk of achieving too high a profile. Such a result could ultimately jeopardize CEPAR's ability to work collaboratively with other institutions. CEPAR must be careful not to fall into the trap of increasingly taking on roles that it can easily handle but that are more appropriately handled by international donors or by the MOH itself. For example, if CEPAR carries out research, analysis, and information dissemination independent of the MOH and the National Statistics Institute (*Instituto Nacional de Estadística y Censos* [INEC]), the project may unintentionally weaken the incentives for these organizations to further develop their own capabilities in these areas.

Ministry of Health

The MOH's ability to participate in Phase 2 has been severely compromised by the turnovers in the presidency of Ecuador and by even more frequent turnovers in the position of minister of health. Within the MOH, serious and myriad structural, managerial, and legal weaknesses have created multilayered barriers that hamper the MOH in fulfilling its mandate to the public and to working successfully with other institutions. Such weaknesses include widespread disagreement among various MOH officials—especially those with many years of service—over reform, modernization, and the MOH's new role; weak leadership and administrative capacities that prevent MOH partners from developing consensus on a Phase 2 workplan; and powerful unions whose frequent strikes cripple normal operations and prevent the MOH from instituting reform measures.

Despite this overall weak context, a number of very positive and very successful reform activities are taking place in specific programs, provinces, and cantóns. Many of these activities were

implemented directly with CEPAR during the first two years of Phase 2, others have been implemented by the MOH with technical assistance from five USAID/Washington (USAID/W) projects: Basic Support for Institutionalizing Child Survival (BASICS), Partnerships for Health Reform (PHR), Rational Pharmaceutical Management (RPM), Quality Assurance (QA), and Opportunities for Micronutrient Interventions (OMNI). Each of these projects works directly with the MOH and has a role with a different configuration of NGO, private, and municipal stakeholders. One of the most successful of these multi-institutional collaborations is being implemented with BASICS for the Integrated Management of Childhood Illnesses (IMCI) throughout the province of Imbabura.

Another constraint to the MOH's ability to productively engage in Phase 2 is the competing demand for attention from two major World Bank projects—Project for the Strengthening of Basic Health Services in Ecuador (*Proyecto Fortalecimiento y Ampliación de los Servicios Basicos de Salud en Ecuador* [FASBASE]) and the Health Modernization Project (*Proyecto de Modernización de Salud* [MODERSA]). These projects have drawn skilled personnel from the MOH's regular ranks to work as a separate team within the MOH. The MOH and USAID/E's challenge in Phase 2 is to identify mutually beneficial field-level activities that can be implemented with FASBASE and MODERSA to promote health reform. For the past year, the MOH had not presented a budget to USAID/E to support any Phase 2 activities. However, at the time of the evaluation, the MOH prepared a two-month budget for USAID/E, a very positive sign for increased MOH commitment to and involvement in Phase 2 activities.

USAID

All persons interviewed agree that USAID/E has made a significant contribution in leadership and investment in the health sector and that this role must be continued by someone when USAID/E terminates its support to health reform activities. During the first two years of Phase 2, USAID/E invested an enormous amount of time coordinating with other donors and public and private organizations to gather support for health reform, and, in particular, Phase 2's new approach. These efforts effectively brought together the major Ecuadorian and international players, including the MOH, the Pan American Health Organization (PAHO), the World Bank, UNICEF, the InterAmerican Development Bank (IDB), and several bilateral donors, for regular discussions about specific proposals for health reform.

In managing Phase 2, USAID/E has focused on developing a climate for health reform so that the NGO partners, CEPAR and APOLO, can implement their own components as effectively as possible. USAID/E's efforts with other donors and stakeholders in the reform process have been crucial to building a strong consensus for health reform at the highest level. Now, USAID/E needs to invest more time to promote synergy among the various Phase 2 components. To date, APOLO and CEPAR have not collaborated in the way that was originally envisioned by the project design nor in other ways that would logically emanate from their complementary efforts in Phase 2. All of the components of Phase 2—APOLO, CEPAR, the MOH, and USAID/W centrally-funded projects—could benefit from closer collaboration on specific issues and in specific places.

The MTE team has made recommendations that can stimulate the synergy needed to move Phase 2 forward; however, USAID's brand new approach to child survival, started in 1995, cannot be expected to show its full potential in only five years, nor was it designed to do so. The original design has now been overridden by USAID's planned phaseout from Ecuador and the termination of its assistance to the health sector when the project is completed on October 1, 2000. If these events take place as planned, they will thwart the CS project's considerable potential.

Major Recommendation for Each Project Component

CARE (APOLO): The experience obtained through the implementation of the demonstration projects should be used to develop a delivery and financing model that combines the expected access, quality, and sustainability criteria and contributes to the reform process. The development strategy for this mode should be oriented toward defining the potential of the diverse experiences and integrating them in a consistent and flexible manner. The resulting model should be so versatile as to incorporate modalities and variations that are adaptable to the scenarios where they are most likely to be replicated.

CEPAR: PAPPS should conduct an internal review of its current activities, as well as the project's personnel and budget capacity. Using the results of this review, PAPPS should highlight those activities most likely to achieve concrete policy changes. The project should then go through a strategic planning exercise, possibly with external technical assistance, that emphasizes cause and effect relationships (using flowcharts, for example) to assess how project activities will result in specific policy changes.

MOH: The MOH should reinforce, with USAID support, the sustainability of those improvements already achieved in the health reform process. Plans for reform activities should take into account the current situation and the proposals issued by important political groups such as the National Health Council.

USAID: Since Phase 2 represents a "new project" in design and approach, it needs to be able to adapt to the reality of USAID/E phaseout by having its own phaseout at the same time as USAID/E's. USAID/E should reconsider the decision to terminate the CS project at the end of FY 2000, preferably extending support for health as long as USAID/E is in Ecuador.

As project manager, USAID must take increased responsibility to work with representatives of the three components (and other USAID projects involved) to develop an integrated vision of the project and a team approach.

LIST OF RECOMMENDATIONS

CHAPTER 4. PRIVATE SECTOR PROGRAM STRENGTHENING (CARE/APOLO)

Demonstration Projects

1. The experience obtained through implementing the demonstration projects should be used to develop a delivery and financing model that combines the expected access, quality, and sustainability criteria and that can contribute to the reform process. The strategy should be oriented toward defining the potential of the diverse experiences and integrating them in a consistent and flexible manner. The resulting model should be so versatile as to incorporate modalities and variations that can be adapted to the scenarios where they are most likely to be replicated.

2. The new model or models should take into account the greater potential for impact when the NGO, the municipality, and the MOH—the elements that determine the reform capability—are closely integrated.

3. Among the demonstration projects observed, Santa Elena has the greatest possibility for configuring a model with significant demonstration potential for health reform. The recommended model incorporates delivery and financing elements with a global and nonpartial view and is based on prior evaluation. If Fundación Pablo Jaramillo decides to develop a peripheral network, it could also become a complete model with high demonstration power.

4. Care must be taken with the terms used to name the demonstration projects. Thought should be given to choose names that are closely attached to the spirit of terms and names accepted by the MOH authorities. Likewise, discretion is recommended for disseminating results where the success of interventions is advertised in advance.

5. Efforts in the current demonstration projects should be targeted to those projects with the greatest potential for being an efficient and sustainable provider (direct effect), as well as potential for replicability (indirect effect). In this sense, the demonstration projects should evolve according to a general model that incorporates their experiences with other effective experiences.

6. The development process for the desired demonstration model will probably require more time than is left in the project. Consequently, the completion date should be extended. Alternatives should be studied for the sustainability of actions implemented by this project component (i.e., APOLO).

7. Chordeleg: Although the delivery of health services can continue as it has, effort should be made to reach an agreement with the MOH to lease its subcenter to avoid duplicating efforts.

8. Fundación Pablo Jaramillo: The project's extension should be carefully planned via preferred providers or peripheral units. This project, as well as Santa Elena, has the potential to establish itself as a delivery and financial model with a good potential for demonstration effect.

9. CEMOPLAF/Otavalo: The child survival services, together with community outreach and targeting of services, should be replicated internally. Given the organization's characteristics, it is unlikely that it can evolve toward a delivery and financing model although some of its characteristics could be replicated within the public and private sectors.

10. With regard to the relationships between APOLO and its partner NGOs, APOLO needs to emphasize to its partners the risks and benefits arising from including any new intervention within their organizations. Special mention has to be made of APOLO's payment of a share of salaries to these institutions. In addition, explicit mechanisms for phasing out this temporary assistance should be defined.

Management Tools

11. The value of the Rapid Feasibility Studies to predict success should be evaluated and its methods defined accordingly.

12. The Monitoring and Evaluation System should be adjusted and completed to more effectively track project activities. This system should accomplish the following:

    - Add morbidity data for measuring the coverage of curative consultations in relation to the target population;
    - Include indicators for measuring the coverage rates of the various services in relation to the population in the target area;
    - Introduce financial and cost-recovery data from the demonstration projects;
    - Automate the system installed in Fundación Pablo Jaramillo for cost calculations that need to be updated regularly;
    - Implement the cost and pricing systems in the other demonstration projects; and
    - Incorporate a follow-up system, including indicators for tracking the quality of services.

13. Adapt the Cost Manual to create a general model not solely reflective of the specific demonstration projects.

14. Because of sample size problems, the follow-up surveys to the baseline (as currently designed) should not be implemented.

15. An annual training plan should be developed based on a prior evaluation of needs and requirements. There should be a survey of opinions of MOH staff at the corresponding levels.

Relationships with CEPAR

16. Closer coordination and support is necessary between CEPAR and APOLO. APOLO should be able to count on CEPAR's support for reaching consensus and commitments with the MOH. Once obtained, such commitments will enable APOLO to develop and implement the proposed model or models.

Interinstitutional Relationships

17. APOLO should continue its strategy for raising awareness among municipalities and for structuring the Cantonal Health Committees where possible. For these actions to be effective, local MOH authorities must be involved and participate.

18. APOLO should do its utmost to optimize coordination with the MOH at the central, provincial, and local levels. Likewise, APOLO should let the MOH know through the most pertinent means that procedures need to be clear for fostering private sector participation. In this respect, it is important to coordinate the promotion of demonstration projects with Ecuador's two major World Bank-funded projects, FASBASE and MODERSA. FASBASE has targeted specific underserved areas of the country to expand the coverage of basic health services. A complementary project, MODERSA, is working in pilot areas to improve health planning and coordination capacities at the local level and to expand the coverage and efficiency of public health services.

19. Resources assigned to centrally funded USAID projects could be better used for APOLO's activities. However, it will be necessary to actively coordinate this collaboration to benefit the project.

CHAPTER 5. ANALYSIS AND PROMOTION (CEPAR THROUGH THE PAPPS PROJECT)

1. PAPPS should continue its current strategy of working with the Ministry of Health, the National Health Council, the Council for Inter-Agency Reform (*Comité Interagencial de Apoyo a la Reforma* [CIAR]), and other health sector donors and institutions to achieve national-level health reform.

2. PAPPS should take more of a background role in Ecuador's health reform process, rather than maintaining a high profile. Specifically in publications and seminars, the project should focus less on promoting CEPAR as an institution and more on collaborating with other institutions to achieve health reform.

3. Wherever feasible, PAPPS should collaborate with the MOH and INEC with an emphasis on strengthening the institutional capacity of these organizations to carry out research, analysis, and information dissemination activities.

4. PAPPS should conduct an internal review of its activities, personnel, and budget capacity. Such a review should allow PAPPS to identify those activities most likely to achieve concrete policy changes. The project should go through a strategic planning exercise, possibly with external technical assistance. This exercise should emphasize cause and effect relationships (using flowcharts, for example) to assess how the various project activities will result in specific policy changes.

5. PAPPS should develop a master plan for training and promotional events, focusing on how specific events will lead to policy reform and other project objectives.

6. PAPPS should develop a master plan for outside technical assistance, focusing on PAPPS and the MOH's needs over the next two to three years.

7. PAPPS's project coordinator should delegate more responsibility and focus more on developing mechanisms and strategies for achieving overall project goals.

8. PAPPS and APOLO should meet regularly to review their projects' objectives and progress and discuss areas for collaboration. If necessary, USAID should take the lead in arranging for this collaboration.

9. PAPPS and USAID/Ecuador should create a TAG, conduct annual—or more frequent—reviews of the project, or find other reasonable mechanisms to provide the project with high-level oversight.

10. PAPPS should continue to involve the MOH in the provincial NGO forums and should seek MOH involvement in the public health schools network. If feasible, PAPPS should actively work with the MOH's NGO coordination office to strengthen this unit to more proactively support and regulate NGOs.

11. PAPPS should develop and implement specific plans to make the NGO forums and the public health schools network self-sustaining organizationally and financially by the end of the year 2000.

12. PAPPS should continue its work with the provinces and cantóns with emphasis on developing a replicable approach to strengthening both levels. A key question is how the project's experience can be replicated in other provinces and municipalities in the absence of significant levels of outside assistance. This replicable approach should take into

consideration that municipalities will be operating with additional funding and responsibility under the new decentralization law.

13. PAPPS should promote cross-fertilization among the different provinces and cantóns in which it is working. Specifically, the three long-term, cantón-level advisors could exchange visits and experiences.

14. PAPPS should carry out an audience segmentation exercise for its research products and publications to ensure that research and publications are coordinated with other project activities and are directly related to bringing about policy changes. This exercise should also emphasize the need for "user friendly" documents for their intended audiences.

15. PAPPS should continue developing and implementing its major health economics studies. The results of these studies and the methodologies developed could be useful for the MOH and at the municipality level in the context of decentralizing resources and planning responsibility in the health sector. Wherever possible, the methodologies and results of these studies should be framed in terms that are easily accessible to national- and local-level decision makers. Methodologies to be applied at the local level should have reasonable data needs so that they can be replicated. When presenting these studies to decision makers, PAPPS should ensure that data limitations are clear.

16. PAPPS should continue to develop its databases and make them available to other organizations and the public.

17. CEPAR and PAPPS should either find a way for CEPAR to sustain PAPPS's database functions beyond the life of the project or develop and implement a plan to transfer these functions to INEC by the time the project ends. This plan should include capacity-building mechanisms so that INEC can effectively provide data to policymakers.

18. PAPPS should use PHR assistance in specific areas mentioned in this report, including collaborating with the MOH, targeting research and publications to specific audiences, strategically planning to analyze how planned activities will result in health reform, and using the press database to influence political decision makers.

19. USAID/E should coordinate with PAPPS and CEPAR to determine where and when the mission can use its influence to assist in the health reform process and reinforce PAPPS's efforts.

20. USAID/E should extend PAPPS as long as is feasible, given budget and administrative constraints.

CHAPTER 6. ROLE AND IMPACT ON THE MINISTRY OF HEALTH

Introduction

Three important proposals for health sector reform have been developed by different institutions:

- The proposal prepared by Social Security's CONAM is under the scope of the reform process within Social Security. This is a well-structured proposal but it lacks the integration and participation of the health sector.

- The proposal presented by the joint Ministry of Health-Ministry of Social Welfare Commission is based on a new National Health System statement. This new approach would reorder the delivery of both public and private health services but will require a strong consensus to be implemented.

- CONASA's proposal is based on sectoral integration. This proposal seeks to improve both the coverage and quality of services and has the advantage of having been developed with the broad participation of the more important health sector institutions.

These proposals constitute very important progress although the processes of reform and modernization are not currently moving forward. The upcoming 1998 transition to a new government has postponed any decisions on approving and implementing these proposals. Given this situation, the following actions could be undertaken now:

Overall

1. Reinforce, with USAID support, the sustainability of those improvements already achieved in the reform process, again taking into account the analysis of the situation and the proposals of important political groups such as the National Health Council.

2. Sponsor discussion groups of relevant public health sector professionals, such as former ministers of recent governments, who are familiar with and supportive of the reform and modernization processes.

3. Generate additional support from important and high-level political groups, such as CONAM, which constitutes the most relevant group for political support to government-level reform.

In addition, it would be convenient to focus USAID assistance by differentiating between central- and provincial-level strategies.

Central Level

4. Support the formation of a health plan that clearly identifies political orientations and priority objectives and emphasizes service equity, quality, and efficiency. This plan should use strategic methods that facilitate their adaptation to the reform and modernization processes. This plan can be submitted as a proposal to the new governmental authorities after the 1998 elections.

5. Continue to support CONASA as a technical and political entity for discussing and formulating reform strategies.

6. Support the formation of a Human Resources Development Plan emphasizing training. The form, content, and evaluation of this training should be in accordance with the reform, modernization, and decentralization processes. The plan should also be based on a permanent analysis of performance of the new roles assigned within all the MOH's technical and administrative levels.

7. Continue to follow and stimulate CIAR activities that will foster joint coordination of efforts and that have already succeeded in integrating other donors.

8. The high maternal and infant mortality rates in Ecuador reflect the need to establish national-level policies and goals emphasizing health care promotion. In this regard, USAID assistance could be even more focused on reproductive health, child growth monitoring, and monitoring and surveillance of prevalent childhood diseases.

Provincial Level

9. Support the establishment and institutionalization of provincial health committees based on political agreements and defined responsibilities.

10. Encourage the MOH to define mechanisms for developing a strategic health plan for every province through the broadest-based participation possible and where adaptation of the reform policies would be prioritized within the political and social context. Similarly, epidemiological analysis is necessary to improve the equity, quality, and efficiency of health services, taking advantage of the results already obtained by IMCI, RPM, and NGOs.

11. Given the different cultural environments of the Sierra and Coast regions, positive experiences can be extracted from the provincial initiatives of important institutions, such as the *Junta de Beneficencia* in Guayas, with its long-term self-sufficiency, and the Fundación Pablo Jaramillo in Cuenca, and the analytical capacity generated by USAID. Additional models could be sponsored that include the same elements of collective support and strategic alliances that permit broad-based participation of civil society in the process.

12. Demographic and cultural realities show that special strategies are needed in provinces with extremely poor ethnic groups, especially those with indigenous populations that constitute a high percentage of the Ecuadorian population. Consequently, technical assistance to assess these groups' anthropological and social realities must be a priority. Throughout its experience in developing child survival projects in Ecuador, USAID has considered these facts and could therefore contribute to designing programs more in accordance with Ecuador's reality.

13. A very important contribution during this reform period will be continued USAID support to the MOH, especially through direct technical consulting services to facilitate dialogue. Until a new government is installed, it would also be possible to continue providing training in support of the reform process, both at the MOH internal level and to other public and private institutions. This training could be on basic topics such as executive management, provincial-level administration and management, local-level operational management, management of quality, and communication and social marketing.

Chapter 7. USAID'S ROLE

USAID's Role in Health Sector Reform

1. Since Phase 2 represents a "new project" in design and approach, it needs to be able to adapt to the reality of USAID/E phaseout by planning its own phaseout to coincide with the mission's phaseout. USAID/E should reconsider the decision to terminate the CS project at the end of FY 2000, and preferably extend support for health as long as USAID/E is in Ecuador.

2. The CS project should be protected from any downsizing with USAID/E, given its short life to date and its need for more intensive USAID contact with implementing partners.

Sustainability of Benefits

3. USAID should focus its efforts on modifying PAPPS and APOLO according to the recommendations from this evaluation so that the results, or benefits, can be sustained beyond the project completion date.

Project Management

Overall

4. If Phase 2 is to reach its true potential with the time and resources available to USAID/E, the USAID management team needs to become substantially involved to take charge of the evaluation recommendations, make midcourse corrections within USAID and externally with APOLO and PAPPS, and closely monitor outcomes.

Promoting Synergy

5. USAID should rebuild the Child Survival team. USAID should reinstate the Project Executive Committee and hold all meetings at USAID in the foreseeable future.

6. As project manager, USAID must take increased responsibility to work with representatives of the three components, and other USAID projects involved, to develop an integrated vision of the project and instill a team approach. In the context of implementing midcourse corrections, possible steps to address this goal include implementing the following:

    (a) Carefully-structured sessions between selected key participants—between CARE and CEPAR, and between the MOH and CARE—to identify and address current feelings of disrespect, anger, and competition.

    (b) A team-building and consensus-building exercise among Phase 2 implementers designed to (1) articulate reasons for working together, (2) identify areas of consensus, (3) understand how the components should work together, and (4) develop specific activities and indicators for moving forward. This exercise should include constructing an integrated project design diagram, including indicators, and should include the supervisors of the coordinators of each component.

    (c) Initially, weekly meetings between USAID and key decision makers within APOLO, PAPPS, and other specified team members to develop specific plans, indicators, and dates for implementing evaluation recommendations. These indicators should not only reflect the end of the Phase 2 project, but should reflect the fact that USAID/E is in a phaseout mode. Once these new plans are approved, they should be included in the amended Cooperative Agreements.

    (d) APOLO and PAPPS could consider using some of PAPPS's consensus-building techniques to help resolve the conflict with the MOH in Chordeleg and promote an integrated approach to health services in the larger health area of Gualaceo.

    (e) PAPPS could use some of APOLO's techniques to develop communications materials for varied audiences.

7. CARE and CEPAR should help direct USAID to key issues where USAID high-level intervention can help build consensus and thus accelerate the reform process. CEPAR should assume a lower profile and allow USAID to make more timely interventions in the policy process. For example, USAID could have a direct line to CONAM.

Communications and Monitoring

8. USAID should have more frequent contact with the APOLO and PAPPS coordinators and additional contact with other members of their respective teams. Maintaining this frequent contact might require additional personnel if the responsibilities and workloads of the current USAID team do not allow them to adjust accordingly.

9. USAID should become more directly involved in monitoring CEPAR and APOLO's activities in the field and from the perspective of their collaborators and clients.

Build Ties for the Future

10. Phase 2's activities can identify and give special support to those members of the MOH who are currently providing excellent collaboration, in areas such as IMCI, to prepare them for the eventual withdrawal of bilateral USAID funding.

11. Members of the evaluation team should be formally authorized by USAID/E to proactively promote the CS project, its current achievements, and its potential to key decision makers in QA, PHR, RPM, BASICS, and OMNI.

Pay Special Attention to APOLO

12. Work with APOLO to identify mutually beneficial opportunities to collaborate with other USAID projects. For example, OMNI is preparing to undertake operations research in iron supplementation of pregnant women. APOLO could facilitate discussions between OMNI and CEMOPLAF (Otavalo or Lago Agrio) for these activities.

1. INTRODUCTION

1.1 Overall Scope

An external midterm evaluation (MTE) of the United States Agency for International Development/Ecuador's (USAID/E) Child Survival and Health Activity (518-0071) was implemented in October and November 1997. This activity is included under the maternal child health services' results package, which is part of the mission's *Strategic Objective (SO) 2: Increased Use of Sustainable Family Planning/Maternal Child Health Services*. The purpose of the midterm evaluation was to review the overall design of the project, including indicators; compare achievements with plans; and make recommendations for midcourse corrections (see Scope of Work in Appendix A).

1.2 Evaluation Team Composition

The evaluation team included the following four international consultants who participated in the evaluation as follows: Mary Ruth Horner, MS, PhD, team leader and specialist in maternal/child health (MCH) program design and evaluation; Carlos Cuellar, MD, MPH, specialist in health services management; Eduardo Navas, MD, MPH, specialist in planning public health services; and Hugh Waters, MPH, specialist in health financing. All team members dedicated additional time after the evaluation to incorporate comments into the report.

1.3 Document Review

The team reviewed selected documents from USAID/E and the three major collaborating agencies: the Ministry of Health (MOH), the Cooperative for Assistance and Relief Everywhere (CARE), and the Center for Population and Family Planning Studies (*Centro de Estudios de Población y Paternidad Responsable* [CEPAR]). Team members also reviewed documents pertaining to their area of responsibility. Other information, such as training data, promotional brochures, and reference documents, was obtained during the course of the evaluation (see Bibliography in Appendix B).

1.4 Key Informant Interviews

The team held discussions with USAID management officials and representatives from the MOH, CARE, and CEPAR. The team also interviewed representatives from five USAID/Washington centrally-funded technical assistance projects; the Pan American Health Organization (PAHO), UNICEF, the World Bank, and Canadian and Dutch development assistance organizations.

1.5 Site Visits

The entire team traveled to the provinces of Azuay and Imbabura to visit facilities and interview people collaborating with various components of the CS project. In Azuay, the team met with

MOH officials, non-governmental organization (NGO) representatives, and collaborators with two of CARE's demonstration projects. The team conducted similar meetings in Imbabura and met with CEPAR staff in Cotacachi. In addition, Dr. Navas visited Guayaquil to meet with key organizations including representatives from the Polytechnic School of the Coast (*Escuela Politecnica del Litoral* [ESPOL]). Dr. Cuellar visited CARE's demonstration project in Santa Elena near Guayaquil. Discussions were held with personnel at each facility visited. (See List of Contacts in Appendix C.)

2. BACKGROUND

2.1 Government

Ecuador is the last South American country (except the Guyanas) to undergo decentralization. Holding on to an inefficient centralized government keeps this fairly small, quiet, and peaceful country from moving ahead as fast as it might in improving economic and social indicators. Although the economy has slowed down since the oil boom of the 1970s and 1980s, it is unnecessarily bottlenecked by outdated governmental structures, policies, and systems. Thus, Ecuador has a long way to go compared to its Latin American neighbors.

Ecuador is currently run by an interim government, known more casually as a government on "standby." Elections are scheduled for May 1998 and the winners will take over in August. Some sectors are optimistic that the new constitution, which is currently being drafted, will lay down a new structure upon which badly needed reform can be built.

USAID's Child Survival and Health Project has been operating in an extremely volatile political context. Since Phase 2's 1995 start date, Ecuador has had three presidents and the turnover, paralysis, and turmoil that inevitably accompany governmental change.

Even more volatile than the government itself has been the office of the Minister of Health. The current minister is the fourth in the past 16 months. USAID, its cooperating partners, its sister organizations, and all other elements of civil society concerned with health issues, especially those of vulnerable segments of the population, are justifiably frustrated by this overall political climate that can and does turn many activists into pessimists.

2.2 Economic Indicators

"Modernization," a familiar topic in the media and among business and professional people, refers to efforts to decrease the overall size of government, especially at the national level. It also refers to the process of privatizing basic services, such as telephones, gas, and electricity. A related concept is decentralization, which refers to the transfer of the locus of power, decision making, and resources from national-level offices to more peripheral levels of government, namely provinces, *cantóns,* and individual communities.

Since the 1980s, real income has decreased; economic growth is staying even with population growth, so the net change is zero and the country does not move forward. Given this stationary status, no extra government funds are available to invest in social services or new ventures. Furthermore, a mere 2 percent of the population controls 70 percent of the wealth and 40 percent of the Government of Ecuador (GOE) budget goes to debt service (versus 17 percent in the United States).

In February 1997, the last president to attempt some serious modernization measures was dramatically driven from office by popular opinion, influenced to a significant extent by very

powerful unions. Thus, at this rate Ecuador is merely delaying the day when it must ultimately face the fact that widespread government inefficiencies and subsidies cannot be sustained.

2.3 Health Indicators

In many countries, the MOH's budget is among the lowest of all sectors and in Ecuador this budget represents less than 2 percent of the total gross domestic product. Within this paultry amount, 77 percent is dedicated to hospitals and secondary levels of health care, while a mere 13 percent is allocated to public health services. This 13 percent is clearly inadequate to cover the full 50 percent or more of the population that lives in abject poverty.

Over the last 10 years, while the overall population has become more urbanized, Ecuador's indigenous population has become increasingly isolated. Without access to adequate health services, this population's health indicators have shown a decline that is masked by national and provincial statistics. Per data from the National Statistics Institute (*Instituto Nacional de Estadística y Censos* [INEC]), the country as a whole experienced a marked decline in the infant mortality rate (IMR) from 76.6 in 1970, to 54.3 in 1980, to 30.3 in 1990. However, this rate has remained unchanged for the first half of the 1990s, suggesting that the health system's ability to achieve continuous improvement over a series of decades is now seriously compromised.

On the surface, a stagnant infant mortality rate and the statistics it embodies are the direct result of limited access to health care in rural areas and overall poor quality MOH services in both rural and urban areas. And, behind these statistics are the factors that affect the MOH's ability to fulfill its mandate for its clientele: the inequitable distribution of resources within government sectors, poor coordination and overt duplication of services, dependence upon centralized systems for resources and decisions, inability to permit local participation, lack of a national health plan, poor management at all levels, disorganized health services provided by the private and NGO sectors, and powerful unions that preserve an irrational status quo.

2.4 Health Reform

As in other countries in the region, Ecuador has a variety of health care providers with overlapping services, including the Ecuadorian Institute of Social Security (*Instituto Ecuadoriano de Seguridad Social* [IESS]), the armed forces, the MOH, and private services. Nevertheless, a significant proportion of the population—30 percent—is without access to even basic health care. Figure 1 depicts the relationships among patients, providers of health services, and funders of health care. The majority of the population is poor, works in the informal sector, or is unemployed and depends on public health services financed by general government revenues.

Figure 1. System for Financing Health Services

Available in hard copy only

An in-depth analysis of Ecuador's health system guided the design of USAID's current CS project. To quote the Executive Summary of the Concept Paper for the redesign (Yamashita, 1994):

> USAID analysis has identified structural problems in the health system, in both the public and private sectors, which limit its ability to increase the production of basic health, primary health care, and child survival services. The fundamental structural problem in Ecuador is that poor role definition and poor coordination among the major producers of health services result in inefficiencies in the production and delivery of health services. These production and delivery inefficiencies in turn limit the availability of and access to basic health care services (i.e., primary health care and ambulatory care services).

More Ecuadorians are showing their willingness to pay for health services, most often because these options are more available, more accessible, and more effective than those offered "free" by the MOH. Even the MOH services have cost implications due to transportation, lost time from work, costs of drugs or supplies, and repeated visits for ineffective treatment. Evidence of this willingness to pay phenomenon is found throughout the country and is not limited to the middle and upper classes nor to urban areas. Figure 2 presents a continuum related to financing and information systems in health care reform, from the lowest level where there is no cost recovery to the highest level where the health care market is quite segmented. The different regions of Ecuador are moving along this continuum at very different rates.

Among health and development professionals and donors, the term "reform" elicits a range of different definitions and the full gamut of aspirations, expectations, and emotions. The concept of reform began to take shape several years ago under one progressive and popular minister of health. However, since his departure the operational definition of reform has, for many, reverted to endless discussions of intangible concepts mired in the current bureaucracy. A well-documented and balanced discussion about health reform in Ecuador written by a respected public health physician was released during the midterm evaluation: *El Proceso de Reforma del Sector Salud en El Ecuador 1992-1997: Aportes para el Debate* (The Process of Health Sector Reform in Ecuador 1992-1997: Input for the Debate).

Figure 2. Evolution of Health Sector Reform

Available in hard copy only

3. USAID'S ASSISTANCE APPROACH

3.1 Historical Perspective

USAID/E began supporting child survival and maternal/child health activities and the MOH in 1985, and initiated the current Child Survival and Health Project with the MOH in 1989. The activity being evaluated began in 1995 and is officially Amendment 8 (also referred to as Phase 2) to the current project. Although originally scheduled to end in May 1999, Phase 2 is expected to be extended for 16 months from May 1999 through September 2000. When this project terminates, it will represent more than 15 years of USAID investment in supporting Ecuador's efforts in child survival and approximately five years investment in health sector reform and modernization.

USAID/E is currently in a phaseout mode in Ecuador. In 1989, the original CS project was funded at $11.7 million; Amendment 8 increased the total funding by $6.3 million, resulting in a final project funding of $18 million. From a historical perspective, Amendments 1 through 7 to the original Child Survival and Health Project were mechanisms to add funds and extend completion dates. Amendment 8, however, represents a radical departure in USAID's approach to supporting improvements in maternal and child health services in Ecuador.

Phase 1 of the CS project was evaluated in mid-1993. As a result, in 1994 USAID decided to embark on a totally new approach and completely redesigned the CS project for Phase 2. This decision changed USAID's approach from one of trying to improve MCH services through the MOH to one of trying to accelerate the process of health sector reform by totally different means. Put into practice, this new approach resulted in a dramatic reduction in the USAID funds available to the MOH for operational support. The vast majority of project funds were reallocated through Amendment 8 to incorporate two NGOs, CEPAR and CARE, directly and substantially into USAID's plan of action. Therefore, Amendment 8, whose title appears deceptively innocuous, actually represented for USAID a new starting point (January 1, 1995) for a new approach with new partners to address health reform in Ecuador.

3.2 Project Goal, Strategic Objective 2, and Intermediate Results

The overall goal remains the same as that of the original 1989 project: To improve the health of infants, children, and mothers in Ecuador. The mission's *Strategic Objective 2* is "*increased use of sustainable family planning and maternal/child health services*." The CS project addresses the MCH component of *Strategic Objective 2* and includes *two Intermediate Results (IR)*:

- *IR3: Improved quality of and access to MCH services*
- *IR4: Increased sustainability of health NGOs*

3.3 Policy Framework

USAID's CS project supports the development and implementation of actions to promote new health reforms in various spheres of civil society. Overall, the GOE is modernizing and decentralizing its policies, structures, and operations. As summarized from Amendment 8 of the Project Grant Agreement, the priority health policies that Phase 2 is designed to address are as follows:

- Targeting public resources to the health needs of the poor;
- Implementing cost-recovery policies and mechanisms for health services;
- Improving the definition of roles and functions among health sector institutions;
- Decentralizing health service delivery to local-level entities;
- Fostering an expanded role for the private sector and municipalities as major providers of health services; and
- Incorporating NGOs, private foundations, and for-profit private entities into health service delivery.

3.4 Project Components

3.4.1 Ministry of Health Policy Reform

This component supports technical assistance, training, and operating costs dedicated to formulating and implementing health sector reform and modernization activities. Specific activities include the following:

- Financing for ESPOL, which has a graduate program in health care administration;
- Support for the MOH's NGO coordinating office, whose mandate includes facilitating agreements between the MOH and NGOs for health service delivery;
- Study tours by Ecuadorian government, labor, and private sector leaders to learn about health sector reforms in other Latin American countries;
- Financial support for workshops, materials, software, manuals, and travel related to health reform and modernization activities; and
- Technical assistance from five USAID/Washington-funded projects:

1. **BASICS (Basic Support for Institutionalizing Child Survival)**: For training in the World Health Organization's (WHO) new paradigm for Integrated Management of Childhood Illnesses (IMCI).

2. **OMNI (Opportunities for Micronutrient Interventions)**: For operations research and social marketing to supplement vulnerable groups with vitamin A and iron and fortify flour with iron.

3. **PHR (Partnerships for Health Reform)**: For assistance in developing and implementing policy reforms to improve equity, efficiency, effectiveness, quality, and sustainability of health systems and modernization of the MOH.

4. **QA (Quality Assurance)**: For improvements in procedures for quality assurance, management, and monitoring systems of health services provided at operational levels.

5. **RPM (Rational Pharmaceutical Management)**: For operations research into public education on appropriate use of basic drugs and for the development of alternative outlets for selling basic drugs.

3.4.2 Analysis and Policy Promotion

This component supports the local NGO, CEPAR, in developing and implementing activities to build a broad-based consensus among Ecuadorian leaders and interest groups on health reform and modernization. These activities include seminars, conferences, advocacy sessions, and NGO forums with representatives of various governmental and non-governmental groups who often hold opposing views. In addition, CEPAR conducts and disseminates analyses and studies on health policy reforms to encourage and promote greater public dialogue on the need to modernize health sector institutions and delivery systems. CEPAR is also testing these principles in two provinces—Azuay and Imbabura—and three cantóns that cover an area equivalent to a county in the United States—Cotacachi, in Imbabura Province; Sucúa, Morona Santiago; and Ventanas, Los Ríos—to transform the theoretical concepts of health reform and decentralization into concrete actions. The budget for this activity is $2 million.

3.4.3 Private Sector Program Strengthening

This component supports CARE in developing the capacity of private sector institutions and municipalities to provide sustainable CS and primary health care services. Through a systematic process, CARE developed criteria for identifying potential collaborating institutions and, once partners were selected, conducted rapid feasibility studies. Baseline surveys helped to assess the most important causes of morbidity and mortality in each partner's catchment area. The resulting ten demonstration projects are located in eight different provinces and are categorized as follows:

- Expansion of services offered (2 projects)
- Expansion of coverage (1 project)
- Integrated health services in Amazonia (1 project)
- Integrated network of health services (1 project)
- Decentralization of services coordinated with the municipality (3 projects)
- Cross-subsidization of health services (1 project)
- Integration of traditional and Western medicine (1 project)

Partners involved in these demonstration projects received subgrants for improving their physical infrastructure, information systems, and training. Such partners include NGOs, the Catholic Church, a private foundation, and municipal governments. The budget for this activity is $3.4 million.

4. PRIVATE SECTOR PROGRAM STRENGTHENING (CARE/APOLO)

4.1 General Description and Objectives

CARE/Ecuador implements the Support to Local Organizations project (*Proyecto de Apoyo a Organizaciones Locales* [APOLO]), which is tailored to strengthen the Ecuadorian health sector policy reforms through the implementation of demonstration projects involving decentralization, alternative financing, service delivery, and expanded access to health services.

The relationship between CARE and the MOH in this project is a fairly unusual one and was deliberately designed that way in CARE's Cooperative Agreement with USAID. CARE is to be evaluated primarily on how well it strengthens private secotor NGOs so the NGOs can play a bigger role in the health sector and thus in health reform. CARE's efforts to develop and test a "decentralized model" that includes the MOH and the local municipality was initially a secondary objective that has grown in importance over time, but that nevertheless remains a secondary objective. However, from the MOH's perspective on and role in APOLO, the decentralized model is the primary objective, because the other models basically do not involve the MOH. For the designers of Phase 2, the CARE component was developed largely as a result of USAID's historical difficulty in working with the MOH; thus, CARE's coordination with the MOH was not an important factor.

The general objective of this project is "to improve the effectiveness, quality, and coverage of child survival and primary health care services through an increased and sustained participation of non-profit private organizations (also known as NGOs) and other private sector entities and municipalities."

The project's specific objectives are as follows:

- To increase the coverage, quality, and financial sustainability of CS and PHC services to low income families in rural and periurban areas through private sector organizations by means of self-financing CS and PHC models.

- To strengthen the institutional capacity of NGOs for planning, budgeting, marketing, administration, and programming of CS and PHC services delivery.

- To develop or improve effective and sustainable coordination mechanisms with public and private sector health care institutions for the delivery of CS and PHC services.

APOLO's three main activities are (1) technical assistance and training to local groups on organizational development, cost recovery, marketing, child survival, and primary health care; (2) subgrants to 10 private organizations; and (3) development of at least five demonstration models.

Since APOLO's inception, the project has worked with approximately 25 for-profit and non-profit private sector institutions to demonstrate new and innovative models for the delivery of low-cost and sustainable health services and provide technical assistance and training.

The following findings and conclusions are based on the evaluation team's observations in the APOLO offices in Quito and the demonstration projects visited in Chordeleg, Fundación Pablo Jaramillo, Medical Center of Orientation and Family Planning (*Centro Medico de Orientación y Planificación Familiar* [CEMOPLAF])/Otavalo, and Santa Elena.

4.2 Impact on the Capacity and Role of the Private Sector, NGOs, and Municipalities as Service Providers

4.2.1 Private Sector Findings

The project assistance provided to the NGOs visited enabled them to improve quality and expand their capacity as service providers by strengthening their organizational, technical, and financial capabilities. Technical assistance and training were complemented with infrastructure support, equipment, and payment to key staff. Examples of assistance provided by the project are as follows:

- **CEMOPLAF/Otavalo**: The package of services was expanded to include a child health program involving IMCI training, infrastructure support, medical and computer equipment support, and implementation of three new delivery units providing pediatric services selected on the basis of epidemiological criteria. Some personnel costs are paid by the project.

- **Fundación Pablo Jaramillo**: IMCI training, infrastructure support, automation of service production records, automation of the user record system to expedite the targeting of subsidies, and provision of a financial information system for costing and pricing services. The latter system has reached a significant level, but further improvements have to be incorporated. The project also covers some personnel costs.

- **Chordeleg**: IMCI training, provision of equipment, technical and management training. The infrastructure support depends on the definition of the transfer of the subcenter lease to the Curia. Some personnel costs are covered.

- **Santa Elena**: IMCI training, infrastructure support, technical assistance, and technical and management training. They do not receive support to pay the staff.

4.2.2 Conclusions

It is certainly possible to improve NGOs' service delivery capabilities through specific interventions comprising technical assistance; training; and support for infrastructure, equipment,

operating costs, and a share of personnel costs. As a result of APOLO's interventions, more services are being offered and the use of services in Chordeleg, Fundación Pablo Jaramillo, CEMOPLAF/Otavalo, and the Cristo Redentor Clinic in Santa Elena has increased. However, support for these organizations is still in the implementation phase and further improvement will be needed to accomplish the project's objectives. The monthly average of curative outpatient consultations before and after APOLO intervention is shown in Table 1.

Table 1

Growth in Outpatient Services at APOLO-Assisted Clinics

Location	Date of Feasibility Study	No. of Consults Per Month at Outset	No. of Consults Per Month Post-Intervention	Date
Otavalo	February 96	412	776	August 97
Chordeleg	April 96	300	403	September 97
Santa Elena	February 97	2,914	3,230	September 97
F.P. Jaramillo	April 96	2,069	2,659	March 97

Source: APOLO Management Information System.

4.3 Impact on Decentralization

The project's impact on decentralization must be seen from two perspectives: (1) contribution to the transfer of power from the central to the local level and (2) contributions to strengthening the capabilities and involvement of local organizations and authorities.

4.3.1 Findings

As a result of the project implementation process in Chordeleg and Santa Elena, the mayor and municipal authorities have become more aware of health issues and are sharing responsibilities in this area. In addition, existing local organizations have been strengthened as evidenced in the Chordeleg Curia's Dispensary, Fundación Pablo Jaramillo in Cuenca, CEMOPLAF in Otavalo, and Cristo Redentor Clinic in Santa Elena. APOLO helped to strengthen these organizations by providing several management tools, research, training, and social mobilization activities. Data was used in the decision-making process in Chordeleg, Fundación Pablo Jaramillo, CEMOPLAF/Otavalo, and Cristo Redentor Clinic.

APOLO was able to work closely with the MOH on immunization activities as evidenced by official vaccination posts operating at Fundación Pablo Jaramillo Clinics, CEMOPLAF/Otavalo, and Cristo Redentor Clinic. However, in Chordeleg considerable coordination with the MOH has not yet resulted in the transfer of the lease of the health subcenter to the municipal committee.

Both the Gualaceo area chief (upon which the Chordeleg subcenter depends) and the province director in Cuenca stated their concerns about the potential duplication of efforts if the project continues to be implemented in the Curia's Dispensary in competition with the MOH's own center.

4.3.2 Conclusions

APOLO's contribution to developing the NGO sector has resulted in greater coverage, improved quality of services, improved ability to recover costs from user fees, and improved managerial skills. In addition, participating NGOs received new management tools (such as the computerized M&E) and as a result, they are now better organized and therefore enabled to participate in and to contribute to the Reform. In short, APOLO is achieving its primary objective (to strengthen private sector NGOs) through a series of specific interventions in existing NGOs (i.e., the demonstration projects).

The project has also contributed to the decentralization process by strengthening local organizations and raising the awareness of the municipalities of Chordeleg and Santa Elena to assume an active role in solving their communities' health problems. Although the process has not yet concluded, the local organizations visited have greater technical and administrative capabilities to face the challenges and responsibilities that will be assigned to them by the MOH or municipalities. Although the decentralized model with the MOH/municipality was considered at the beginning as a secondary objective, it has definitely grown in importance over time. For the MOH, it should be the primary objective and quite logically, they have expressed considerable interest in increasing coordination and learning more from APOLO's other demonstration projects.

Coordinating activities with the MOH is much easier when implementation of interventions does not depend on using MOH facilities or resources and when self-determining and long-standing organizations are involved (e.g., Fundación Pablo Jaramillo, CEMOPLAF/Otavalo, and Cristo Redentor Clinic).

A potential for duplication of effort exists in Chordeleg because the lease for Chordeleg's MOH subcenter has not yet been transferred. As a result of this duplication of effort in such a small market, sustainability of the APOLO-assisted project is seriously hindered and its contribution to the decentralization process is limited.

4.4 Local Capacity to Participate in Health Reform Activities

Local capacity to participate in the health reform process is related to the synergy level that can be achieved through the combination of the demonstration project's efforts, municipality support, and coordination with the MOH. The integration of these factors will largely determine a project area's potential as an efficient and sustainable provider (direct effect) and its potential to be replicated (indirect effect).

4.4.1 Findings Indicating the Demonstration Project's Areas of Influence

Fundación Pablo Jaramillo: The technical and managerial capability achieved through this institution's experience can enable other NGOs to strengthen local capabilities. This institution's high credibility may have an influence on the MOH's willingness to foster private sector involvement. The Fundación has a limited relationship with the municipality and currently coordinates operations with the MOH to provide immunizations.

CEMOPLAF/Otavalo: This site can serve not only as a model to be replicated by CEMOPLAF but also as a demonstration model to be used by similar organizations.
CEMOPLAF has no relationship with the municipality, yet does coordinate operations with the MOH (for immunizations and IMCI).

Chordeleg: A mayor who is sensitive to the new Decentralization and Social Participation Law can disseminate his experience among his peers and health authorities. The weak point for this site is the lack of effective coordination with the MOH.

Santa Elena: Three important elements are present in this locality: (1) a mayor who is motivated and aware of the health problems, (2) a local infrastructure manifested by the Curia at Santa Elena (owner of the Cristo Redentor Clinic) and five dispensaries currently being organized into a health services network; and (3) good coordination with the MOH local unit.

4.4.2 Conclusions

The project areas visited have the potential capabilities to participate in reform activities directly as well as indirectly. However, integration of the three elements that determine the capability for participation in health reform (NGO, municipality, and MOH) is only evident in Santa Elena. Consequently, Santa Elena may have a greater capability to participate. Fundación Pablo Jaramillo and CEMOPLAF/Otavalo are focused on specific technical and managerial interventions (targeted subsidies and diversification of the package of services) that can be replicated. If Fundación Pablo Jaramillo develops a peripheral network, it could also become a good demonstration site. Table 2 shows the relationship among the three elements in the four project sites.

Table 2

Role of the NGO, Municipality, and MOH in Four Demonstration Projects

Demonstration Project	NGO Role	Municipality Role	MOH Role
Chordeleg	The Curia at Chordeleg administers and provides service delivery support in its own dispensary.	Municipality involved and committed. There is a Cantonal Health Committee, with no participation by the MOH.	Coordination problems. MOH does not participate.
F. Pablo Jaramillo	Foundation administers and provides economic support to one clinic's activities. It does not yet have a peripheral network.	The Municipality is not involved.	Held in high regard by local MOH authorities. There is operational coordination in immunizations and IMCI.
CEMOPLAF/ Otavalo	Administered and fully supported by headquarters in Quito, it is part of a national network mainly involved in FP activities.	The Municipality is not involved.	There is operational coordination in immunizations, IMCI, and FP.
Santa Elena	The Curia at Santa Elena administers and supports the Cristo Redentor Clinic and five dispensaries.	Municipality involved and committed. There is a Cantonal Health Committee, with MOH participation.	Held in high regard by local MOH authorities. There is operational coordination in immunizations and IMCI.

The demonstration projects have incorporated one or two specific interventions into already existing models. The current concept of the demonstration projects does not anticipate the development of a general model that includes the lessons learned during this experimental phase. Such an output could be useful for promoting reform.

4.5 Usefulness and Quality of the Managerial Tools

4.5.1 Findings

Rapid Feasibility Studies (RFS): According to the organizations interviewed, the RFS studies enabled them to better know their own organization, field of action, and market. For the APOLO team, these studies were used not only for making a decision to work in a given place but also for determining the type of intervention or demonstration project to be implemented.

Monitoring and Evaluation System (M&E): While the M&E is well structured in general and being implemented or used in the various demonstration projects, the following must be noted:

- The information regarding medical services does not include morbidity data to enable the projects to measure the coverage of curative consultations in relation to the population in the area of influence.

- The technical indicators used only make it possible to compare what was achieved to what was planned. They do not include indicators for measuring coverage rates of the diverse services in relation to the target population as a whole.

- With regard to financial data, APOLO's system does not yet include financial data or information related to cost recovery in the demonstration projects.

- The cost system installed in Fundación Pablo Jaramillo is appropriate but needs to be updated on a regular basis manually. The cost system within the targeted subsidy model is appropriate and effective. The staff knows how to use this system.

- As for the CEMOPLAF projects, cost-recovery calculations and other financial data are carried out in CEMOPLAF's central offices in Quito.

- In the other demonstration projects visited, the cost and pricing systems had not yet been implemented.

- APOLO does not yet have quality indicators or a system for tracking the quality of services.

The Cost Manual: Technically well developed and appropriate for the level and needs of Fundación Pablo Jaramillo, but not necessarily adequate for the other demonstration projects.

Baseline Studies: An important support while planning the demonstration projects' activities and strategies. However, the sample size seems to be insufficient to measure statistically significant differences, such as infant mortality rates.

Method to Create Effective Equity: Allows the identification of risk factors at the social (geographical), family, and individual levels so that preventive, promotional, and curative actions can be targeted. Used in the CEMOPLAF demonstration project in Otavalo, this method is a valuable input to project objectives.

Qualitative Research for Social Marketing: Used together with the RFS to understand community opinions and level of acceptability for the services offered. After projects were implemented, this method was used to learn clients' perception of service quality.

Training: Provided upon request by the supported NGOs and also to address those specific needs established during the RFS. Training was provided through three methods: (1) formal courses, (2) in-service training, and (3) observation tours. A group of officials from the supported NGOs and

the MOH had a very productive study tour of the PROSALUD's childbirth attention system in Bolivia. The MOH also requested assistance from members of the APOLO management team for training activities.

4.5.2 Conclusions

The set of management tools developed by the APOLO project team is useful and is being applied at the central level and by the supported NGOs. The Rapid Feasibility Studies and the baseline studies have been instrumental for making decisions about demonstration sites and models to be developed. Although considerable progress has been made, implementation of the Monitoring and Evaluation System at the central level and with the NGOs is insufficient. Additionally, the cost system has been developed but not yet implemented and adapted to each NGO's needs.

Training activities have been performed to address the needs defined by the APOLO team, as well as the specific requirements of the supported NGOs.

4.6 Verifiable Results at End of Project

4.6.1 Conclusions

The period established for the selection of projects and the planning and implementation of the demonstration projects was longer than expected. For that reason, progress made during the project's lifetime will not reach a point where the demonstration effect can influence the reform process. However, one or two integrated models could emerge from the demonstration projects that, even if they are not totally completed, could establish the conceptual basis for the potential and actual role of the private sector and its relationship with the municipalities and the MOH.

It is necessary to again stress that the status of the M&E does not allow it to measure results as desired. As indicated, to attain measurable results, some improvements to the M&E must be made, including the implementation of the financial systems. Also, the sample size and universe of the baseline studies will not be sufficient by the end of the project to demonstrate statistically significant differences.

4.7 Feasibility of the Demonstration Projects' Objectives

4.7.1 Findings

In general, the objectives of the demonstration projects are feasible, but corrective actions are needed for the M&E and financial systems. Additionally, some improvements are needed in the demonstration projects:

- **Fundación Pablo Jaramillo**: Feasibility of the objectives largely depends on the type of extension strategies (e.g., preferred providers or peripheral units) to be defined.

- **CEMOPLAF/Otavalo**: Feasibility of objectives depends on the sustainability level of peripheral units, especially at Iluman.

- **Chordeleg**: Feasibility of the long-term objectives would be seriously compromised if an agreement with the MOH is not reached for the lease of the subcenter.

- **Santa Elena**: Objectives are feasible and depend on the development and integration of the network including the incorporation of the Curia's five dispensaries.

4.7.2 Conclusions

The feasibility of the demonstration projects largely depends on upcoming actions and decisions. With Fundación Pablo Jaramillo, CEMOPLAF/Otavalo, and the Cristo Redentor Clinic, the factors affecting their feasibility are essentially internal. In the case of Chordeleg, the key factor is external: the lack of an agreement with the MOH concerning the subcenter.

4.8 Sustainability Goals of the Demonstration Projects

Table 3 contains an analysis of the sustainability of the demonstration projects observed.

Table 3

Analysis of Sustainability Elements of Four Demonstration Projects

Project	Element				
	Institutional	**Social**	**Technical**	**Financial**	**Policy/Social**
Chordeleg	Sustainable as institution, but demonstration project sustainability depends on its ability to reach an agreement with the MOH.	Depends on the quality and acceptance of services by the community.	Needs: 1) strengthening of IMCI and implementation of a MCH program 2) MOH supervision and monitoring	Conditions: 1) That MOH accepts implementation of cost-recovery and other financial strategies. 2) To define how personnel costs currently paid by the project will be assumed.	Condition: Continued municipal support
Fundación Pablo Jaramillo	Sustainable. The model will require an agreement with the MOH and/or municipality if peripheral units are chosen for expansion.	Good quality and acceptability of clinic services. These indicators must be followed by preferred providers or peripheral units.	Technical components such as IMCI need follow-up. There is institutional capability to maintain good service quality.	Conditions: 1) That the cost and pricing system is implemented and institutionalized. 2) To define how personnel costs currently paid by the project will be assumed.	Strong and sustainable.
CEMOPLAF/ Otavalo	Sustainable. The model will require agreement with MOH or with private providers for childbirth services in order to complete the package of services.	Good quality and acceptability of clinic services by the community. Monitoring of these indicators in the peripheral units to be done.	The IMCI component only needs follow-up until it is consolidated within the institution. In the MCH program, the best system for attention at birth has not yet been defined.	Conditions: 1) To reach an agreement with the MOH, who has to accept the implementation of cost recovery in its center in Otavalo. 2) To define how personnel costs currently covered under the project will be paid.	Strong and sustainable.
Santa Elena	A sustainable institution. The model is supported by the municipality & local authorities. A Cantonal Health Committee with wide social participation has been established.	Good quality and acceptability of the clinic services by the community. A critical element will be the incorporation of the Curia's five dispensaries as a network.	The IMCI component only needs follow-up. Improvement in the system for attention at childbirth will be done when the building improvements are completed.	Conditions: 1) To establish the service network of the Curia's health center and the five peripheral dispensaries. 2) To reach a more formal agreement with the MOH.	Strong and sustainable.

4.9 Replicability of the Demonstration Projects

Assuming that the demonstration projects attain their objectives, their replicability must be analyzed by defining the elements to be replicated and their potential beneficiaries. The important criterion for this analysis is the maintenance of benefits rather than of the project itself or its implementing institution, recognizing that these two elements are interrelated.

Table 4

Analysis of Replicability Elements of Four Demonstration Projects

Project	Definition	Replicability		
		Internal	For Other NGOs	For the MOH
Chordeleg	Private administration of public services by a church organization received on lease and having municipal support through a health committee.	N/A	It is replicable if MOH clearly states conformity for the participation of private organizations in the administration of public services. This implies establishing clear, stable rules of the game.	N/A
Fundación Pablo Jaramillo	1) Participation of a foundation, established by a socially sensitive business family that offers a public health service; 2) A focused subsidy system; 3) A network associated with a central clinic (in the future).	N/A	1) With difficulty; 2) Yes, if NGO has a strong management organization; 3) Yes, depending on MOH political decision, if public facilities are to be used for expansion.	1) N/A; 2) Yes. It needs technical assistance, capital investments and important changes of current policies; 3) Yes, the aspects for optimizing a network.
CEMOPLAF/ Otavalo	1) Provider of family planning services in process of expanding its package of services by incorporating Child Survival; 2) A community outreach system for Child Survival services.	Yes, it can be replicated within its own network	1) Yes, it could be a possibility where CS services are not available; 2) Yes, it can contribute to improve CS services where these are available.	1) N/A; 2) Yes, it requires technical assistance and training.
Santa Elena	Administered by a church organization that is part of a network including one clinic & 5 dispensaries in a defined geographical area. The model has the participation of the municipality and local MOH authorities as a part of a Cantonal Health Committee.	N/A	Experiences and concept of service network at two levels (primary and secondary) in a limited geographical zone is replicable by other NGOs, especially the church. F. Pablo Jaramillo and CEMOPLAF could benefit from this experience.	Yes, it would be easier because MOH services are distributed by geographical levels. It requires technical assistance and training.

General Conclusions

1. The project has contributed to strengthening the NGO sector, which has resulted in greater coverage, improved quality of services, improved ability to recover costs from user fees, and improved managerial skills.

2. The project, by implementing the demonstration projects, raising awareness among municipalities, and providing other support interventions to NGOs, has contributed to the reform/decentralization process by strengthening local organizations and authorities.

3. The management tools developed by the APOLO team have been useful in determining the intervention sites and implementing the demonstration projects. The APOLO team spirit and professional competence is shown through their accomplishments.

4. The Management Information and Cost Systems have advanced but have not been completely implemented. These systems are instrumental for continued project implementation and follow-up.

5. IMCI training has been implemented and is being applied at the operational level. This training has already improved the quality of child health care.

6. As a result of the project, the APOLO-supported NGOs have improved their potential to participate in reform activities directly as efficient and sustainable providers and indirectly as models that can be replicated.

7. The potential impact of the Santa Elena project is greater because of the integration of the three elements that establish capability for contributing to decentralization (NGO, municipality, and MOH). Contributions to specific technical and managerial aspects of reform by Fundación Pablo Jaramillo and CEMOPLAF/Otavalo are limited but no less important.

8. Relationships between APOLO and its partner NGOs are generally good even though the team observed communication problems related to the possibilities and risks for the NGOs from incorporating interventions into their organizations. There is a lack of information about the disadvantages and risks of the interventions in Fundación Pablo Jaramillo and Chordeleg. Furthermore, there are doubts about the project's future contributions to cover personnel costs.

9. The implementation of the demonstration projects has not yet been concluded and in some cases is just beginning; consequently, the projects are unlikely to be completed by the end of the project.

10. Operational coordination with the MOH is difficult, especially when transferring MOH facilities is required. In the case of projects whose implementation does not depend on the

MOH and when autonomous and long-standing organizations (Fundación Pablo Jaramillo, CEMOPLAF/Otavalo, and Cristo Redentor Clinic) are involved, coordination is easier but still limited to operational issues (i.e., immunizations, IMCI).

11. The Chordeleg project needs to solve its operational coordination problems with the MOH to achieve success, that is, to have a demonstration effect capable of contributing to the reform.

12. Fundación Pablo Jaramillo is already a successful model with great potential for a demonstration effect. For the specific replication of the targeted subsidies (known as *Plan Carné*), the system for identifying the capacity of users to pay for services would be difficult to implement on a large scale (big cities) and depends on the social workers' knowledge and fairness. Furthermore, large investments would be necessary for its automation and training.

13. CEMOPLAF/Otavalo is a feasible model that can be replicated especially within CEMOPLAF's networks of clinics. Notable are not only the expanded package of services but also the community outreach and targeting of child survival activities.

14. The Santa Elena project combines elements that provide greater demonstration potential for a decentralized model. The municipality, as well as the MOH and the NGO (Curia of Santa Elena), have the opportunity to implement a model that could have a greater impact and that can incorporate elements from other demonstration projects.

15. Thanks to CARE/APOLO's efforts, funding from other donors has been leveraged. Donors include the Dutch Cooperation in Chordeleg, the Canadian Cooperation (three demonstration projects), and CARE/Atlanta and CARE International. Furthermore, the synergy between APOLO and other CARE activities contributes to more efficient use of resources.

16. The APOLO team's professional qualities and devotion should be emphasized. The team has good morale and good internal coordination, and it adequately records and documents activities.

17. CARE is using CEPAR's data and documents, but CEPAR is not using the results from CARE's demonstration projects to promote revisions in health policies. These entities collaborate in specific events but have not developed common strategies and objectives. For example, APOLO needs to count on clear rules of the game for stimulating private sector participation, a task that could perfectly fit within CEPAR's role. In addition, the team noted a strong sense of competition between the two projects and, consequently, a lack of required synergy. Instead, both organizations are trying to promote their own institutions and projects instead of trying to achieve the project's basic results.

Recommendations

Demonstration Projects

1. The experience obtained through implementing the demonstration projects should be used to develop a delivery and financing model that combines the expected access, quality, and sustainability criteria and that can contribute to the reform process. The strategy should be oriented toward defining the potential of the diverse experiences and integrating them in a consistent and flexible manner. The resulting model should be so versatile as to incorporate modalities and variations that can be adapted to the scenarios where they are most likely to be replicated.

2. The new model or models should take into account the greater potential for impact when the NGO, the municipality, and the MOH—the elements that determine the reform capability—are closely integrated.

3. Among the demonstration projects observed, Santa Elena has the greatest possibility for configuring a model with significant demonstration potential for health reform. The recommended model incorporates delivery and financing elements with a global and nonpartial view and is based on prior evaluation. If Fundación Pablo Jaramillo decides to develop a peripheral network, it could also become a complete model with high demonstration power.

4. Care must be taken with the terms used to name the demonstration projects. Thought should be given to choose names that are closely attached to the spirit of terms and names accepted by the MOH authorities. Likewise, discretion is recommended for disseminating results where the success of interventions is advertised in advance.

5. Efforts in the current demonstration projects should be targeted to those projects with the greatest potential for being an efficient and sustainable provider (direct effect), as well as potential for replicability (indirect effect). In this sense, the demonstration projects should evolve according to a general model that incorporates their experiences with other effective experiences.

6. The development process for the desired demonstration model will probably require more time than is left in the project. Consequently, the completion date should be extended. Alternatives should be studied for the sustainability of actions implemented by this project component (i.e., APOLO).

7. Chordeleg: Although the delivery of health services can continue as it has, effort should be made to reach an agreement with the MOH to lease its subcenter to avoid duplicating efforts.

8. Fundación Pablo Jaramillo: The project's extension should be carefully planned via preferred providers or peripheral units. This project, as well as Santa Elena, has the

potential to establish itself as a delivery and financial model with a good potential for demonstration effect.

9. CEMOPLAF/Otavalo: The child survival services, together with community outreach and targeting of services, should be replicated internally. Given the organization's characteristics, it is unlikely that it can evolve toward a delivery and financing model although some of its characteristics could be replicated within the public and private sectors.

10. With regard to the relationships between APOLO and its partner NGOs, APOLO needs to emphasize to its partners the risks and benefits arising from including any new intervention within their organizations. Special mention has to be made of APOLO's payment of a share of salaries to these institutions. In addition, explicit mechanisms for phasing out this temporary assistance should be defined.

Management Tools

11. The value of the Rapid Feasibility Studies to predict success should be evaluated and its methods defined accordingly.

12. The Monitoring and Evaluation System should be adjusted and completed to more effectively track project activities. This system should accomplish the following:

    - Add morbidity data for measuring the coverage of curative consultations in relation to the target population;
    - Include indicators for measuring the coverage rates of the various services in relation to the population in the target area;
    - Introduce financial and cost-recovery data from the demonstration projects;
    - Automate the system installed in Fundación Pablo Jaramillo for cost calculations that need to be updated regularly;
    - Implement the cost and pricing systems in the other demonstration projects; and
    - Incorporate a follow-up system, including indicators for tracking the quality of services.

13. Adapt the Cost Manual to create a general model not solely reflective of the specific demonstration projects.

14. Because of sample size problems, the follow-up surveys to the baseline (as currently designed) should not be implemented.

15. An annual training plan should be developed based on a prior evaluation of needs and requirements. There should be a survey of opinions of MOH staff at the corresponding levels.

Relationships with CEPAR

16. Closer coordination and support is necessary between CEPAR and APOLO. APOLO should be able to count on CEPAR's support for reaching consensus and commitments with the MOH. Once obtained, such commitments will enable APOLO to develop and implement the proposed model or models.

Interinstitutional Relationships

17. APOLO should continue its strategy for raising awareness among municipalities and for structuring the Cantonal Health Committees where possible. For these actions to be effective, local MOH authorities must be involved and participate.

18. APOLO should do its utmost to optimize coordination with the MOH at the central, provincial, and local levels. Likewise, APOLO should let the MOH know through the most pertinent means that procedures need to be clear for fostering private sector participation. In this respect, it is important to coordinate the promotion of demonstration projects with Ecuador's two major World Bank-funded projects, Project for the Strengthening and Expansion of Basic Health Services in Ecuador (*Proyecto Fortalecimiento y Ampliación de los Servicios Basicos de Salud en Ecuador* [FASBASE]) and the Health Modernization Project (*Proyecto de Modernización de Salud* [MODERSA]). FASBASE has targeted specific underserved areas of the country to expand the coverage of basic health services. A complementary project, MODERSA, is working in pilot areas to improve health planning and coordination capacities at the local level and to expand the coverage and efficiency of public health services.

19. Resources assigned to centrally funded USAID projects could be better used for supporting APOLO's activities. However, it will be necessary to actively coordinate this collaboration to benefit the project.

5. ANALYSIS AND PROMOTION (CEPAR THROUGH THE PAPPS PROJECT)

5.1 Overall Description and Objectives

In May 1995, CEPAR and USAID signed a Cooperative Agreement creating the Analysis and Promotion of Health Policies Project (*Proyecto Análisis y Promoción de Políticas de Salud* [PAPPS]). PAPPS represents a significant portion of CEPAR's current activities and approximately 60 percent of its current budget. PAPPS's overall objective is to

> contribute to the health reform process in Ecuador, through research, policy analysis, dissemination of information, and promotion of dialogue and debate, in order to achieve the policy focus and consensus necessary for the implementation of structural and organizational changes in the health sector.

PAPPS's specific objectives, as detailed in project documents and the Cooperative Agreement, are as follows:

- Identify and promote health policy reform;
- Promote the efficient allocation of resources with an emphasis on providing preventive health care, implementing cost-recovery policies, and providing incentives for the production and delivery of health care;
- Carry out studies in support of health reform and on alternative forms of financing;
- Promote policy reform at the provincial and cantón levels, encouraging community participation and strengthening the ability of these levels to act in the health sector;
- Conduct consensus-building seminars to disseminate information related to health reform and bring about changes in public attitudes concerning the health sector; and
- Promote improvement in the definition of roles within the MOH, with the MOH becoming an entity mainly focused on establishing sector norms and supporting policy planning, supervision, and evaluation.

5.2 Impact on the Process of Health Reform at the National Level

5.2.1 Findings

PAPPS has played an important role in supporting the National Health Council's (*Consejo Nacional de Salud* [CONASA]) efforts to promote health reform. Either separately or with other institutions, PAPPS has financed and organized more than 25 seminars and workshops on health

sector reform. Approximately 2,000 representatives of institutions in the health sector have attended these events. Furthermore, a series of provincial, PAPPS-supported seminars has focused on the appropriate role of the MOH, the role of the private sector in providing health services, and specific policy priorities.

Additionally, PAPPS has played an important role in assisting the Congressional Health Commission (*Comisión Especial Permanente de Salud y Saneamiento Ambiental*). The project has had input in promoting a law to ensure financing for vaccines. Also, PAPPS has been working with the commission to change a proposed law regulating NGOs that would have potentially negative implications for health sector NGOs.

PAPPS's other national-level promotional activities include publishing CEPAR's journal, the *Correo Poblacional y de la Salud* (Population and Health Mail), sending specific information to key leaders via fax or "Ceparfax," and developing radio spots for national and provincial radio stations.

5.2.2 Conclusions

PAPPS and CEPAR's strategy to achieve health sector reform has included (1) disseminating information; (2) conducting research; (3) promoting consensus among universities, the Ministry of Health, the Ecuadorian Social Security Institute (*Instituto Ecuadoriano de Seguridad Social* [IESS]), and the Congress; and (4) working in specific provinces and cantóns. This strategy appears well founded and realistic; however, to achieve maximum synergy the project's many activities could be better coordinated in terms of the different target audiences.

PAPPS has successfully promoted policy dialogue on health reform in Ecuador. A key element in this success has been the positive relationships between the project and other institutions involved in the health sector, including government institutions, universities, NGOs, and donors. Another key element has been the skill and dedication of the staff. CEPAR has supported CONASA's health reform efforts and provided valuable organizational and technical assistance to the health reform process in 1995 and 1996.

Largely because of political factors outside the project's control, the promotion of policy dialogue has not yet resulted in most of the significant policy changes foreseen in the Cooperative Agreement. The health reform process is likely to take a considerable amount of time, and PAPPS has an important role to play in this process.

USAID/E may be able to help PAPPS in promoting health reform by using its political influence to assist with specific, pertinent issues. This type of intervention requires close coordination between PAPPS and the USAID mission.

5.3 Relationships with Other Organizations and Institutions

5.3.1 Findings

CEPAR and PAPPS have worked collaboratively and successfully with a wide range of national and international health sector organizations. These organizations include other NGOs, universities, government institutions, the Congress, and international donors.

With regard to PAPPS's relationship with the MOH, relations have varied with changes in government and changes in ministers, but in general, relations have been positive. Meetings of the Project Executive Committee (*Comité Ejecutivo del Proyecto* [CEP]), which includes the MOH, USAID, CEPAR, and CARE, have been suspended due to instability in the MOH. Amendment 8 calls for CEPAR to develop project workplans in coordination with the MOH and other government institutions. This activity is not currently being done. The MOH is focusing on internal reform efforts through the Ministry of Health Restructuring Committee (*Comité de Restructuración del Ministerio de Salud*). One of the objectives of the CS project's component to support the MOH (separate from USAID's Cooperative Agreement with CEPAR) is to develop and strengthen the MOH's NGO coordinating office to promote, monitor, and evaluate NGO health programs. PAPPS has been involved in organizing and coordinating NGO forums, but the NGO coordinating office in the MOH has little influence and remains relatively weak institutionally. As to PAPPS's relations with the MOH at the provincial and cantón levels, PAPPS has maintained good relationships with provincial health directors, as well as with officials at the municipal level, working in the social sectors.

PAPPS's relations with the National Health Council were very good during the first half of 1996 when the council was meeting regularly and was the primary vehicle for discussing specific policy proposals. However, the council is not currently active.

PAPPS's relations with INEC have generally been positive. PAPPS provides some computing equipment to INEC. PAPPS is fulfilling some of the functions of INEC, specifically, providing data and data analysis for various health sector participants.

With regard to PAPPS's relations with USAID, CEPAR and USAID meet formally an average of 10 times per year and informal meetings and coordination have been regular. USAID provides written feedback on PAPPS's semiannual reports. USAID representatives have participated in PAPPS-supported provincial workshops.

The Cooperative Agreement between CEPAR and USAID calls for a Technical Advisory Group (TAG) of three to five prominent independent individuals to review the overall direction of the program and provide recommendations through semiannual meetings. This group has not been formed, partly because it was thought that the CONASA meetings would fulfill the TAG's role. The Cooperative Agreement also calls for annual evaluation reviews to determine whether activities have been completed and interim objectives met as planned, especially for impact on policies.

As to PAPPS's relations with CARE and APOLO, there has been very little formal contact between PAPPS and APOLO since the Project Executive Committee (CEP) meetings ended.

PAPPS's collaboration with MODERSA has been good and several activities related to health reform have been cofinanced by the two groups. CEPAR maintains a signed agreement with PAHO, and relations between PAHO and PAPPS have been positive.

PAPPS's relations with the Congressional Health Commission have been very good. CEPAR plans to install a health information database in the commission and train a commission staff member to use this database.

5.3.2 Conclusions

PAPPS and CEPAR's ability to work collaboratively with other organizations is a strong asset in promoting health reform. However, CEPAR may create resentment among some other health sector institutions by continuing to maintain a high profile and promote its own activities.

PAPPS and APOLO could collaborate in many ways since their ultimate goals are very similar. Logically, PAPPS should use the results of APOLO's demonstration projects to argue for policy reform. Although APOLO is using PAPPS's data and information, information does not appear to flow in the opposite direction. Additionally, the two projects should be coordinating activities in the field. USAID could play a positive role in promoting coordination between the two projects.

PAPPS could benefit from more high-level oversight from USAID/E to coordinate health reform efforts.

5.4 Coordination of NGOs and Public Health Schools

5.4.1 Findings

PAPPS has helped create NGO forums in the provinces of Pichincha and Azuay and is working toward forming a regional NGO forum in the eastern part of Ecuador. The project has provided these forums with data and information, supported workshops for training methodologies, and helped with coordination. The forum in Pichincha has more than 50 members and has been meeting approximately once a month. The members of the Azuay forum feel that they can continue activities independently of PAPPS assistance.

PAPPS's input has also been important in forming a national NGO forum. Since many of the functions of the national forum are being carried out by the Pichincha forum, the national forum has not been meeting regularly.

As a result of the project's work in organizing and coordinating NGOs, the NGO community has provided input into a proposal for a law to regulate and coordinate NGOs.

The MOH maintains an office for coordination with NGOs in the health sector, but this office is not currently viewed as strong or influential. A representative of this group has attended meetings of the Pichincha NGO forum.

Finally, PAPPS has organized and served as coordinator for a network of public health schools (*Red de Programas de Formación de Recursos Humanos a Nivel de Post Grado en Salud Pública*), with 14 member institutions. The network has held bimonthly meetings but has not yet begun producing a bulletin, which is one of its objectives.

5.4.2 Conclusions

In the provinces where they have been formed, the NGO forums have led to a positive debate on reform and a strengthening of NGO coordination.

The network of public health schools has been a useful forum for collaboration among the schools. However, this network has limitations as a mechanism for rationalizing inputs into the training of health professionals because of the diverse nature of the schools (some are public, some private) and the fact that they are competitors for training resources and students.

The public health schools network does not have active participation from the MOH. An MOH representative has attended some of the meetings of the Pichincha provincial NGO forum but is not actively involved in the organization of the forum. MOH participation is important to enable these groups to act as effective representatives of their members in government regulation and public-private coordination. The MOH does not currently have the ability to actively coordinate and organize NGOs.

Both the NGO forums and the public health schools network are currently dependent on PAPPS for organizational and financial support.

5.5 Activities at the Provincial and Cantonal Levels

5.5.1 Findings

Decentralization of the health sector and other social sectors is rapidly becoming a reality. The Congress has approved a law stating that 15 percent of the national budget will be spent at the municipality level. A significant portion of the government's budget for health already goes directly from the Ministry of Finance to hospitals and health areas, which generally correspond geographically with cantóns and municipalities.

At the provincial level, PAPPS has worked in Loja, supporting a provincial committee for health reform; in Imbabura, through a workshop on social participation in health and local development and follow-up activities; in Azuay, supporting a provincial committee in coordination with PAHO; and in Manabí. The project has also supported the creation of NGO forums in Pichincha, Azuay, and the eastern region.

PAPPS has been principally involved in three cantóns that represent Ecuador's three principal geographic regions: Cotacachi in Imbabura Province, Sucúa in Morona Santiago Province, and Ventanas in the province of Los Ríos. PAPPS has also been working with the cantón of Cuenca, supporting a workshop to develop a proposal for integrated health promotion.

In Cotacachi, PAPPS has supported the *Comité Intersectorial de Salud*. The mayor of Cotacachi is president of the committee, and the director of the Cotacachi Hospital is the executive secretary. The committee maintains four commissions for research and promotion in specific areas and is actively developing a cantonal health plan. Furthermore, with input from the Cotacachi Health Committee, PAPPS conducted a survey of health problems and practices in the cantón. The mayor and the committee were satisfied with this survey and stated that it would be helpful in making plans and investment decisions.

In Cuenca, the cantón is developing an integrated health plan (*plan de salud integral)* with assistance from PAPPS. The province of Azuay (which includes Cuenca) has definite plans for a meeting to prepare a provincial health reform plan.

5.5.2 Conclusions

In the context of health sector decentralization, identifying ways to help municipalities manage additional responsibility and resources is a high priority. Many municipalities do not have the requisite experience or staff to meet this challenge. Additionally, it is important to define and support the role of the provincial MOH authorities in a scenario where municipalities have considerable financial resources and autonomy. In this context, PAPPS's experience in working with cantóns and provinces to strengthen health planning could be extremely useful.

A key challenge for PAPPS, and for other health sector participants, is to develop cantón-level experiences that are replicable in other cantóns. So far, it is not clear if PAPPS's experience in Cotacachi and other cantóns is replicable. The project has invested considerable resources in this activity, including a full-time project employee dedicated to working with the Cotacachi cantón health committee. It is not clear, however, how a similar intersectoral committee could be formed and sustained in other cantóns without such resources.

There is general agreement that the municipalities should not assume responsibility for service delivery, but rather should play a coordinating and promoting role among the different public and private organizations providing health services within the municipality.

PAPPS's provincial- and cantón-level activities have led to increased social and political awareness of the importance of health. In Cotacachi, a youth group formed by the cantón health committee is actively supporting the mayor, providing an additional political incentive for the mayor to work with the health sector. In Cotacachi, an intersectoral vision of health—with health care and promotion not just the responsibility of the MOH or the social security programs—is developing. An additional positive result of PAPPS's involvement is the development of cantón and provincial health plans.

PAPPS has learned valuable lessons through its work with the cantóns. The process has been complicated by the fact that the committee members have different backgrounds, training, and experiences. PAPPS's employees working in the cantóns of Cotacachi, Sucúa, and Ventanas could have a useful exchange of experiences by visiting each other.

5.6 Research Studies and Other Technical Documents

5.6.1 Findings

PAPPS has prepared a national health sector analysis with demographic and epidemiologic data and information on health infrastructure and human resources. The project has prepared similar documents for Ecuador's southern region and for a total of 14 provinces and 6 cantóns. These documents clearly demonstrate the inequities in Ecuador in terms of health status and access to health services.

In health economics, PAPPS has taken the lead role in several major research studies, including conducting cost-effectiveness analyses nationwide and in the cantón of Cotacachi, and calculating national health accounts. The principal objectives of the cost-effectiveness methodology include prioritizing public health interventions and research projects, as well as identifying groups and areas that are disadvantaged or need special attention. The study is the first major study of its type in Latin America.

The cost-effectiveness analysis study in Cotacachi is broad in scope, including a methodology for defining the costs of a package of essential services, and qualitative research techniques for determining the principal health care delivery issues from the perspective of each of the principal health sector participants. The study includes maps marking the areas covered by specific health facilities and showing areas of noncoverage and overlap. The units of analysis for effectiveness are measured in healthy years of life or disability-adjusted life years (DALY). Much of the epidemiologic data for the study has been collected at the Asdrúbal de la Torre Hospital in Cotacachi.

The national health accounts study seeks to compile a register of health expenditures from all sources, including the government, households, private health care providers, insurance companies, NGOs, and international cooperative assistance. The study has been contracted to CEPAR by the Harvard University School of Public Health as part of USAID's PHR project. In Ecuador, CEPAR has involved other organizations, including INEC, in implementing this study. Data sources for the study include information available from government sources, existing household surveys, and primary data collection through surveys of private providers and private insurers.

Other influential documents published by the project to date include *Desarrollo Histórico de las Políticas de Salud en el Ecuador (1967-1995)* (Historical Development of Health Policy in Ecuador [1967-1995]) and, in conjunction with Ramiro Eheverría, *El Proceso de Reforma del*

Sector Salud en el Ecuador 1992-1997: Aportes para el Debate (The Process of Health Reform in Ecuador 1992-1997: Input for the Debate).

5.6.2 Conclusions

Generally, CEPAR's technical work is held in high regard. The Process of Health Reform document is useful and comprehensive; other documents, including the demographic and epidemiologic profile documents, have been helpful in health sector planning. In Azuay, the provincial socioeconomic profile has been very helpful for health planning in the province. Similarly, the epidemiologic analysis for the cantón of Cuenca has been useful. However, organizationally and technically, the MOH is not ready to use some of the more sophisticated documents and tools prepared by PAPPS.

PAPPS's documents address a wide variety of health sector and government professionals. However, the project does not appear to have a master plan for targeting specific audiences with specific publications, describing how the documents will result in policy changes.

The health economics study using cost-effectiveness analysis is a potentially useful tool in PAPPS's efforts to assist the MOH and municipalities in health planning. A straightforward methodology, accessible to those responsible for health planning at the local level, is a major contribution to effective health sector decentralization. The clear definition of costs can help with determining needs for cost recovery. A major strength of the methodology used in this study so far is that it includes qualitative information on problems and issues related to service delivery from the perspective of the public and the different service delivery professionals.

The national health accounts study is likely to be most useful at the national level since it can be difficult to disaggregate the data available to the provincial and cantón levels. The participation of INEC and other local organizations in this study is a positive point that should reinforce INEC's research capacities.

Both major studies can be helpful for health planning in Ecuador. However, it should be noted that for both studies there are missing and imperfect data. For the national health accounts study, data are incomplete for private providers and insurers, international cooperation, and NGOs. For the cost-effectiveness analysis, the relationship between inputs (in terms of financial or human resources) and outputs (in terms of DALY or similar measures) is approximate. PAPPS has done a good job of developing approaches to make up for missing data.

5.7 Information Databases

5.7.1 Findings

PAPPS's health information databases have achieved recognition in the health sector as organized and available data sources. The types of information available include epidemiological, socioeconomic, morbidity and mortality, human resources, and health providers by type and by

services provided. CEPAR has received requests from UNICEF, CARE, PAHO, IESS, and other organizations, as well as from students and other individuals and from the Congressional Health Commission.

The principal health information database will be transferred to the Congressional Health Committee, and a committee staff member will be trained to use it. At present, the database has been transferred to INEC. Much of the data originally comes from INEC, but INEC does not have a strong reputation for efficiently providing the data to outside users. PAPPS has purchased computers and other equipment for INEC.

PAPPS has also developed a database for press articles on health and health reform containing summaries of approximately 1,400 articles dated through June 1997. A separate bibliographic database contains references to more than 1,000 documents.

5.7.2 Conclusions

PAPPS's health information databases have been of high quality and have been useful for organizations and individuals involved in health sector planning. The press database could be very helpful in influencing policy development, particularly by demonstrating to political leaders that health reform is a politically important issue since it is receiving attention in the press and in public debate.

An unfortunate and unintended by-product of the success of CEPAR's health databases may be that INEC will be bypassed as a source of information and will have little incentive to improve its operations. If the PAPPS project ends and other funds are not available to continue its functions, the ultimate effect may be to weaken the provision of information in Ecuador's health sector. CEPAR's sustainability plan and ability to continue specific PAPPS functions without continued USAID assistance are very important in this context.

5.8 Training and Promotion Events

5.8.1 Findings

PAPPS has directly organized and funded 38 training and promotional events with 1,660 participants. Such events have included workshops, seminars, and study tours. Further, either directly or with other organizations, PAPPS has organized and funded 116 events with 5,694 participants. The most common topics of these events have been health reform, the strengthening of provincial and municipal capacities, NGOs and health systems, human resources training, and health economics. PAPPS has also conducted additional informal training and capacity building through PAPPS's personnel working in the cantóns.

5.8.2 Conclusions

In addition to having a direct capacity-building effect, PAPPS's training and promotional events have played an important role in opening health reform for discussion and sensitizing health personnel and other national- and provincial-level decision makers to the importance of reform. These different events have also provided a forum for coordination among organizations working in the health sector.

The sheer number of events that PAPPS has been involved in organizing and the wide range of topics addressed suggest that to achieve change, the project should focus its training and promotional efforts with fewer events that fit into a focused plan.

5.9 External Technical Assistance

5.9.1 Findings

External technical assistance to PAPPS includes the following:

- Visits early in the project by consultant Larry Day of John Snow, Inc., that focused on proposals for health financing reform;
- Support through the PHR project for several specific studies and assignments, including the cost-effectiveness study, the global burden of disease study, and the drug supply in the context of decentralization study.
- Support from Harvard University (also through the PHR project) for studies on political mapping and national health accounts.

5.9.2 Conclusions

PAPPS has not taken a lead role in identifying and requesting specific technical assistance needs for the project or for the MOH. However, the project is well placed to identify specific ways that external assistance can help with the health reform process in Ecuador.

General Findings and Conclusions

Findings

PAPPS is involved in a wide variety of national-, provincial-, and cantón-level activities. Through PAPPS's activities and those of its other projects, CEPAR has achieved a reputation for technically sound analysis and gained a high profile in Ecuador's health sector. CEPAR is well known, and its identity is prominent in publications and events in which CEPAR and PAPPS are involved.

From the start of the project in May 1995 to August 1997 (58.5 percent of the original project duration), PAPPS had spent 47.3 percent of its overall budget.

CEPAR and PAPPS have developed a sustainability plan that includes diversifying funding sources, recovering some costs by selling products, and providing services and consultancies to the public sector and international donors. However, funding for PAPPS's current activities is uncertain beyond the year 2000.

The CEPAR staff in general and PAPPS's staff in particular are technically competent and motivated. PAPPS's staff work fluidly with other staff at CEPAR, and the project is well supported by CEPAR's different sections. Further, CEPAR has successfully integrated the PAPPS project into the overall structure of the organization. PAPPS has not sought to establish a separate identify from CEPAR but has worked in the context of the organization's overall activities and priorities.

Conclusions

Since PAPPS is involved in many different types of activities simultaneously and the project's promotional component is addressing different types of audiences, it is not always clear how the activities will result in specific policy changes. The project should have more high-level oversight to ensure that the link between project activities and objectives is clear.

The staff of PAPPS may be overextended and involved in too many activities, many of which require travel. This is particularly true for the project coordinator.

Because of the many activities it is involved in and the number and visibility of its publications, PAPPS may risk achieving too high a profile in the health sector. Having too high a profile could ultimately jeopardize the project's ability to collaborate with other institutions to achieve health reform. As a project run by an NGO, PAPPS must pay careful attention to ensure that it is not seen as taking on roles that are more appropriately played by international donors or by the MOH itself. Furthermore, if PAPPS carries out research, analysis, and information dissemination independently of the MOH and INEC, the project may unintentionally weaken these organizations' incentives to strengthen themselves institutionally, since some of their key functions will be fulfilled by an NGO.

CEPAR and PAPPS have successfully sought to maintain the public identity of the project (PAPPS) within the identity of the organization (CEPAR). In publications, seminars, and informal publications, the name "CEPAR" generally precedes "PAPPS" and is given more weight. Given CEPAR's high level of credibility and the fact that PAPPS is an impermanent project, this strategy is effective and appropriate.

With regard to PAPPS's relationship with USAID/Ecuador's Strategic Objectives, within *Strategic Objective 2* the CEPAR component of the CS project has had a direct impact on *IR4, "Increased sustainability of health NGOs"* through PAPPS's activities supporting the creation and continuation of NGO forums. Further, PAPPS has had an indirect impact on *Strategic Objective 2, "Increased use of sustainable family planning and maternal child health services,"* through policy reform and sensitization. A concrete example of this impact is the project's input into the passing of a law ensuring GOE funding for vaccines.

Because of the nature of the project, which focuses on health policy and health reform, project accomplishments are subject to Ecuador's general political climate. As stated in the Cooperative Agreement between CEPAR and USAID,

> a critical assumption underlying the achievement of the Strategic Objective is that an appropriate policy environment will exist which will enable private sector organizations to expand primary health care services, which will improve the targeting of subsidies, and which will better define the roles of the numerous health sector actors.

Recommendations

1. PAPPS should continue its current strategy of working with the Ministry of Health, the National Health Council, the Council for Inter-Agency Reform (*Comité Interagencial de Apoyo a la Reforma* [CIAR]), and other health sector donors and institutions to achieve national-level health reform.

2. PAPPS should take more of a background role in Ecuador's health reform process, rather than maintaining a high profile. Specifically in publications and seminars, the project should focus less on promoting CEPAR as an institution and more on collaborating with other institutions to achieve health reform.

3. Wherever feasible, PAPPS should collaborate with the MOH and INEC with an emphasis on strengthening the institutional capacity of these organizations to carry out research, analysis, and information dissemination activities.

4. PAPPS should conduct an internal review of its activities, personnel, and budget capacity. Such a review should allow PAPPS to identify those activities most likely to achieve concrete policy changes. The project should go through a strategic planning exercise, possibly with external technical assistance. This exercise should emphasize cause and effect relationships (using flowcharts, for example) to assess how the various project activities will result in specific policy changes.

5. PAPPS should develop a master plan for training and promotional events, focusing on how specific events will lead to policy reform and other project objectives.

6. PAPPS should develop a master plan for outside technical assistance, focusing on PAPPS and the MOH's needs over the next two to three years.

7. PAPPS's project coordinator should delegate more responsibility and focus more on developing mechanisms and strategies for achieving overall project goals.

8. PAPPS and APOLO should meet regularly to review their projects' objectives and progress and discuss areas for collaboration. If necessary, USAID should take the lead in arranging for this collaboration.

9. PAPPS and USAID/Ecuador should create a TAG, conduct annual—or more frequent—reviews of the project, or find other reasonable mechanisms to provide the project with high-level oversight.

10. PAPPS should continue to involve the MOH in the provincial NGO forums and should seek MOH involvement in the public health schools network. If feasible, PAPPS should actively work with the MOH's NGO coordination office to strengthen this unit to more proactively support and regulate NGOs.

11. PAPPS should develop and implement specific plans to make the NGO forums and the public health schools network self-sustaining organizationally and financially by the end of the year 2000.

12. PAPPS should continue its work with the provinces and cantóns with emphasis on developing a replicable approach to strengthening both levels. A key question is how the project's experience can be replicated in other provinces and municipalities in the absence of significant levels of outside assistance. This replicable approach should take into consideration that municipalities will be operating with additional funding and responsibility under the new decentralization law.

13. PAPPS should promote cross-fertilization among the different provinces and cantóns in which it is working. Specifically, the three long-term, cantón-level advisors could exchange visits and experiences.

14. PAPPS should carry out an audience segmentation exercise for its research products and publications to ensure that research and publications are coordinated with other project activities and are directly related to bringing about policy changes. This exercise should also emphasize the need for "user friendly" documents for their intended audiences.

15. PAPPS should continue developing and implementing its major health economics studies. The results of these studies and the methodologies developed could be useful for the MOH and at the municipality level in the context of decentralizing resources and planning responsibility in the health sector. Wherever possible, the methodologies and results of these studies should be framed in terms that are easily accessible to national- and local-level decision makers. Methodologies to be applied at the local level should have reasonable data needs so that they can be replicated. When presenting these studies to decision makers, PAPPS should ensure that data limitations are clear.

16. PAPPS should continue to develop its databases and make them available to other organizations and the public.

17. CEPAR and PAPPS should either find a way for CEPAR to sustain PAPPS's database functions beyond the life of the project or develop and implement a plan to transfer these functions to INEC by the time the project ends. This plan should include capacity-building mechanisms so that INEC can effectively provide data to policymakers.

18. PAPPS should use PHR assistance in specific areas mentioned in this report, including collaborating with the MOH, targeting research and publications to specific audiences, strategically planning to analyze how planned activities will result in health reform, and using the press database to influence political decision makers.

19. USAID/E should coordinate with PAPPS and CEPAR to determine where and when the mission can use its influence to assist in the health reform process and reinforce PAPPS's efforts.

20. USAID/E should extend PAPPS as long as is feasible, given budget and administrative constraints.

6. ROLE OF AND IMPACT ON THE MINISTRY OF HEALTH

6.1 General Description and Objectives

According to the Amendment 8 workplan, the MOH component comprises the following:

1. Modernizing MOH/institutional reform
2. Strengthening maternal/child health programs
3. Strengthening MOH management and administration capabilities

Before presenting the results of USAID's support to the MOH, some background on the MOH's operational environment is required. USAID's efforts have been quite substantial in supporting the three elements of the MOH component; however, the MOH's institutional response has faced many difficulties, including political instability, a systemic and well-entrenched resistance management and administrative changes, and weak planning processes.

During the last year, only a few important decisions have been made; consequently, the MOH's capacity to use the funding allocated to this component has been very limited and, largely because of the lack of planning, few financial disbursements have been made during the project's lifetime. Of the total funding allocated to these activities, only 32 percent has been requested and spent. Currently, the MOH is developing a workplan for November 1997 through September 1998, including activities in the following areas:

- Modernization of the MOH
- Training
- Strengthening of foreign assistance policies
- Quality improvement
- Decentralization
- Support to IMCI
- Information systems
- Support to rational use of drugs
- Monitoring and evaluation
- Maternal mortality reduction

- Epidemiological surveillance
- Strengthening of the MOH's administrative and managerial capabilities

In spite of the MOH's institutional weaknesses, USAID's assistance has been successful in promoting consensus on the need for reform, decentralization, and institutional reorganization. Encouragingly, the MOH's new annual plan allocates part of USAID support to these purposes. Although USAID assistance to the reform process has lead to important accomplishments, the modernization component has moved slowly. The MOH has a profound institutional weakness especially in the planning area; consequently, no plan exists that clearly delineates future actions.

USAID support to the decentralization process has elicited a weak response at the central level, although consideration must be given to the fact that any MOH response requires a political and legal framework to make the decentralization process effective. Such a condition has not been created; therefore, centralized systems continue with limited participation. Furthermore, the decentralization process has been focused at the central and local levels with little activity, changes, or advantages evident at the provincial level. This gap represents a constraint to the working relationships between the central and the operating levels.

It has not been possible to use USAID assistance to develop a training plan to address the shift of functions and new management and administration styles required by the modernization process. The reform process brings with it new responsibilities and staff performance methods that will require intensive training. Unfortunately, the lack of a Human Resources Development Plan and the shutdown of the National Training Institute constitute key barriers that delay training activities. As a result, the current cadre of MOH staff is generally unable to respond to the needs of the new organization and management models.

USAID's efforts to support modernization are further impeded by the MOH's current administrative and financial structure. The MOH allocates approximately 80 percent of its budget to cover hospital costs due to the centralized structure, pressure exercised by the trade unions and public opinion for hospital services, the growing costs of health care, and general management and administration inefficiency. This situation is complicated further because 87 percent of the MOH's general budget is allocated to personnel costs, leaving only a limited amount for investment in operating expenses, infrastructure and equipment maintenance, and critical public health activities dedicated to health promotion and prevention. All of these factors result in very limited targeting of activities to the poorest and most vulnerable population groups, especially considering the high percentage—approximately 20 percent—
of the indigenous population whose cultural environment further limits their access to services.

6.2 Project Support to the MOH

6.2.1 USAID-Supported Projects

Congressional Health Commission

USAID has been successful within the political context in the excellent working relationship developed with the Congressional Health Commission, which is assisted by CEPAR. This commission has sponsored legislation that has been subsequently endorsed by the National Congress, such as the law passed in September 1997 guaranteeing permanent financing in current value for vaccines and other inputs for the national Expanded Programme of Immunization (EPI). This law overcomes one of the major difficulties in implementing the MOH's preventive maternal/child care programs.

Another important advance is the signing of a Cooperative Agreement between the National Congress's Special Commission for Health and Environmental Sanitation and CEPAR. In addition to the other important items included in this agreement, responsibility is placed on the commission to arrange for resource allocation and participation of national and international specialists in the reform process.

Another law passed by the National Congress and supported by USAID is the Special Law for State Decentralization and Social Participation (*Ley Especial para la Decentralización del Estado y Participación Social)*. Article 7 of this law refers to the distribution of 15 percent of the national government's budget to lower-level—especially municipal—governments and Article 9a grants authority to the municipalities to "plan, coordinate, implement, and evaluate integrated health, nutrition, and food security plans for their populations, with emphasis on the most vulnerable social groups." This law constitutes a very important advance in the reform process and although the mechanisms for its regulation and observance have not yet been established, it represents a crucial legal framework for future actions.

Decentralization of Administrative and Financial Systems

USAID's fostering of the decentralization process has resulted in several important decisions for making the MOH's administrative and financial systems more flexible. For example, the budget assigned to financing operational health areas can be directly allocated and delivered to these areas without having to go through the central-level bureaucratic process, on the condition that these areas have the infrastructure required for adequate financial administration.

Rational Pharmaceutical Management

With USAID support, the design and implementation are successfully underway for an integrated plan for the purchase, distribution, and use of basic drugs. This plan will be especially used in operational health areas in close coordination with the Essential Drug Programme, so that the poorest clients have timely access to these supplies.

The project for Rational Pharmaceutical Management was initiated in June 1997 as a model of interinstitutional cooperation through the Health and Life committee, under the leadership of the municipality of Ibarra. This initiative was formulated using advice from the MOH and support from USAID's Rational Use of Drugs in Healthy Schools Program (*Uso Racional de Medicamentos en Escuelas Saludable* [URMES]), and constitutes an innovative experience that enables the school population and the community to participate in the process of change through local operational models.

Integrated Management of Childhood Illnesses

MOH management of the maternal/child health sector is taking advantage of successful models, such as the IMCI project through which positive experiences of integrated health care have been obtained. The program's strategy comprises four commissions: Communications, Operations Research, Management, and Training. This approach facilitates the program's organization and its support to other sector institutions. In addition, IMCI's strategy and training modules developed with PAHO-WHO can be adapted for implementation at the local level within the cultural and operative framework of the service delivery units. IMCI also allows for integration of content from other related MCH programs such as diarrheal disease control and growth monitoring. In Imbabura province, a training plan for IMCI has been designed and is now being implemented. This plan gives priority to the MOH staff and takes into account other sector officials as well. A total of 272 nurses, doctors, and other staff have been trained in IMCI in Imbabura.

National Health Council

USAID's support to the National Health Council's activities and CEPAR's role as facilitator for developing proposals for health reform, as well as the technical assistance and information provided to the council, has enabled the council to hold meetings and workshops to analyze health sector reform. This assistance has also created a favorable environment for necessary changes among all the institutions and the public.

Quality Assurance Project

USAID assistance through QA has supported the development of 21 demonstration projects with a focus on three provinces. This effort has received support from the University Research Corporation and the Center for Human Services whose main objective is to contribute to developing methods and techniques for improving the quality of MOH services.

The National Program for Quality Improvement (*Programa Nacional de Mejoramiento de Calidad* [PNMC]) has supported the training of approximately 350 professionals and health workers in quality assurance methods and techniques. An evaluation plan for the PNMC is currently being developed. If a training plan with the proposed contents is applied and sustained, it will have a major positive impact on services.

Cost Recovery and NGOs

USAID support for the Presidential Agreement authorizing cost recovery constitutes an accomplishment that makes it possible to introduce reforms in health sector financing and self-sufficiency. In this context, collaboration with NGOs will be very important. However, approaches for implementing and regulating this new decree are still under discussion. The MOH's NGO office is very weak and a law for regulating NGOs is still pending. A strengthened NGO forum could constitute a strategy for executing the Presidential Agreement.

6.2.2 Direct Support to the MOH

USAID's assistance to improve the MOH's management capability has included an agreement with ESPOL. ESPOL's Graduate School of Administration runs a program in postgraduate health management. This program was designed using private business concepts of service delivery; therefore, little emphasis is given to public health and important basic thematic areas, such as epidemiology, equity of access, and risk factors. School officials are open to redesigning the program to better address MOH staff needs.

Other aspects that compromise MOH staff's effective participation in this program are high course fees, which are due to the need to attract international specialists as professors, and the enrollment process, which includes technical criteria that not all public sector candidates can meet. These elements could be taken into account during new negotiations with USAID.

The ESPOL program lasts one year and includes several on-site activities and a tutorial "back home" that extends the course time. Consequently, the program's short-term performance can not be evaluated. The reputation and self-sufficiency of the Polytechnical School support its continuation and provides flexibility for revising the program's curriculum to better suit the MOH's needs. The curriculum can be redesigned if justified by the related costs and number of students.

Conversely, the organized network of public health schools constitutes another possibility for collaboration in the teaching process based on agreements with existing training institutions. With the cooperation of institutions located close to the students' work places and the establishment of a good evaluation system, the most successful schools could be selected to expand training access.

Institutional Policies

Despite USAID's efforts to modernize MOH institutional policies, progress has been impeded by the variable nature of current policies and lack of defined change strategies.

Another impediment in this area concerns the allocation of USAID funding among the three Amendment 8 components. In prior amendments, a large portion of project funds was allocated to the MOH; however, in Amendment 8 most of this assistance is channeled through institutions like CEPAR and CARE. Because of this new funding strategy, some MOH officials are reluctant to

collaborate on the proposed activities because they argue that these funds belong to or should be allocated directly to the MOH to use at its discretion.

Maternal/Child Health Programs

USAID assistance devoted to improving MCH programs has been concentrated mostly at the central level in the design of plans and norms. Although the plan to reduce maternal mortality has received important central-level political support, at the provincial level strategic activities have not yet been applied to the extent required to have the expected impact. The types of provincial-level activities needed are epidemiological surveillance of maternal deaths, adequate attention at birth, and especially pregnancy monitoring with quality of care and focus on risk factors. This gap at the provincial level is also affecting the local level because the lack of required provincial-level support has prevented the local level from being able to revise its health care models to meet user needs. Therefore, USAID support should be focused on the provincial level by strengthening the decentralization process (both programmatically and operationally) and thereby leaving the function of political and regulatory decisions to the central level.

Interinstitutional Collaboration

CIAR, created with USAID support, has successfully linked the efforts of a variety of donors and agencies, resulting in a more coherent approach toward technical assistance and financial support. For example, PAHO, which provides technical assistance, is closely collaborating with two World Bank projects—MODERSA and FASBASE—to support the modernization and reform process. This strategic alliance helps foster the participation of other donors in the process. USAID's participation has been critical as the facilitator of these interinstitutional alliances.

6.2.3 Support to NGO Forums

USAID support to NGO forums in the provinces of Pichincha and Azuay has considerably strengthened the organization and coordination of participating members. Other provinces do not yet have this type of organization, thus limiting their ability for coordination.

6.3 Implementation Problems

The following major problems limit the MOH's ability to productively engage in the reform process:

1. The lack of a clear and defined policy in accordance with the reform and decentralization process.

2. The lack of a strategic plan, which results in poor overall management, scattered activities, and noncohesive programs. To complicate this situation, the MOH's traditional administrative approach creates vertical programs with little integration.

3. The major challenge in the reform process is to succeed in making changes feasible and sustainable at all levels. This objective can only be attained through a clear definition of the operational strategy and on the basis of a training plan designed from a performance analysis. If these conditions are not met, all efforts will be weak and easily lost among day-to-day issues.

4. Possibilities of working with the MOH are restricted, due to the lack of organization and management capability and to inefficiency and internal conflicts.

6.4 Conclusions

6.4.1 Reform Component

Important progress has been made toward developing technical capacity and promoting the reform process; however, the MOH's modernization process has not advanced. The process of health reform has undergone the following three stages:

- Initiating health reform
- Generating and discussing proposals
- Expecting and waiting for political decisions

During the five-year period from April 1995 through October 1997, USAID's contributions, especially through CEPAR's activities, have been critical in fostering discussion among representatives of various sector institutions and in stimulating the development of proposals. The National Health Council's support to this process has been instrumental in gaining the participation of the most important participants in the process. Unfortunately, this process is now delayed.

The major challenge that USAID assistance faces is to enable the MOH to sustain the progress of the reform process and, consequently, to have a direct impact in the future.

One of USAID's greatest achievements has been its assistance in creating a legal framework for the reform process through legal and Congressional agreements. An important impact of USAID's assistance on sector reform is the promotion of the reform concept itself as seen in proposals to reduce state participation in the delivery of services and to embrace broader acceptance by the MOH of social and private participation. Considering the political importance of reform, it could be convenient to promote a closer relationship with the National Modernization Committee (*Consejo Nacional de Modernización* [CONAM]) for collaboration at the highest political level to sustain the process.

Another very valuable USAID achievement is its fostering of other donors' participation in the reform and modernization processes. An example of such success is the establishment and operation of CIAR.

Raising political awareness of and generating support for the reform process has been part of USAID's very important intervention. This work has been acknowledged by important political leaders such as former Ministers of Health, Dr. Alfredo Palacios and Dr. Francisco Huerta, and by legislators who are members of the Health Commission in the National Congress.

6.4.2 Decentralization Component

USAID's support to the passing of a general decentralization law is from the legal viewpoint a very important step in the process. However, this legislation's lack of clear and defined regulations results in diverse interpretations and confusing operating approaches. One example of this problem is the varied interpretation of how municipalities can use their 15 percent national budget allocation.

Support to decentralization as a process of transferring power and resources has been primarily focused on the operational health areas, postponing strategic adaptation at the provincial level. The resulting gap reduces the provincial level's ability to provide essential support and weakens the overall process due to the lack of sustained participation.

Decentralization within the reform context is resulting in additional demands on unknown or previously unregulated administrative systems, such as those related to contracting personnel, cost recovery, and new treatment protocols. All of these systems require continued USAID assistance to identify problems and improve operational response at the provincial level.

The roles of the central, provincial, and health area levels must be clearly defined to continue their restructuring and modernizing in accordance with their working relationships with mayors, municipalities, NGOs, and other institutions. The lack of defined roles results in conflicts and confusion that impairs the process.

6.4.3 Modernization of the MOH Component

Of the three components, the MOH component has progressed most slowly. However, the MOH has now established an Institutional Strengthening Committee to clarify its objectives for participating in the modernization and reform process, simplify bureaucratic process, restructure the organization, and create more feasible approaches for interinstitutional coordination. Part of USAID's financial support is being requested for this committee.

Because of the lack of a national health plan, the modernization process suffers from serious constraints, such as the lack of a clear orientation and a defined political and technical process.

Labor troubles and institutional disagreements show that management weaknesses in strategic negotiation only make the situation worse. This problem could be overcome by a plan to improve institutional leadership.

With regard to innovative demonstration projects, these activities have had positive small-scale experiences in the area of purchasing, storing, and distributing drugs to health areas. These demonstration projects have negotiated directly with pharmaceutical producers and distributors, which has reduced cost and improved access to basic drugs.

Other positive achievements through USAID-supported projects include use of IMCI; development of the URMES model; integration of the basic maternal/child package into the CEMOPLAF services in Otavalo; and participation of mayors and municipalities, such as Cotacachi, in the health reform process.

Furthermore, the Santa Elena project, supported by USAID through CARE, is perhaps one of the best models for proving that management with private participation is possible. This project is also self-sufficient and has broad-based community participation.

The role of USAID in monitoring the trends and adequacy of the political context has been very difficult. Nevertheless, in spite of frequent government changes and institutional weaknesses, USAID has made important progress that should be reinforced to promote sustainability. Consequently, additional efforts are required to address the problems affecting USAID's contractors and their counterparts. Actions need to be focused on the key aspects of the process that are very fragile and that could take a wrong turn.

6.5 Recommendations

Introduction

Three important proposals for health sector reform have been developed by different institutions:

- The proposal prepared by Social Security's CONAM is under the scope of the reform process within Social Security. This is a well-structured proposal but it lacks the integration and participation of the health sector.

- The proposal presented by the joint Ministry of Health-Ministry of Social Welfare Commission is based on a new National Health System statement. This new approach would reorder the delivery of both public and private health services but will require a strong consensus to be implemented.

- CONASA's proposal is based on sectoral integration. This proposal seeks to improve both the coverage and quality of services and has the advantage of having been developed with the broad participation of the more important health sector institutions.

These proposals constitute very important progress although the processes of reform and modernization are not currently moving forward. The upcoming 1998 transition to a new government has postponed any decisions on approving and implementing these proposals. Given this situation, the following actions could be undertaken now:

Overall

1. Reinforce, with USAID support, the sustainability of those improvements already achieved in the reform process, again taking into account the analysis of the situation and the proposals of important political groups such as the National Health Council.

2. Sponsor discussion groups of relevant public health sector professionals, such as former ministers of recent governments, who are familiar with and supportive of the reform and modernization processes.

3. Generate additional support from important and high-level political groups, such as CONAM, which constitutes the most relevant group for political support to government-level reform.

In addition, it would be convenient to focus USAID assistance by differentiating between central- and provincial-level strategies.

Central Level

4. Support the formation of a health plan that clearly identifies political orientations and priority objectives and emphasizes service equity, quality, and efficiency. This plan should use strategic methods that facilitate their adaptation to the reform and modernization processes. This plan can be submitted as a proposal to the new governmental authorities after the 1998 elections.

5. Continue to support CONASA as a technical and political entity for discussing and formulating reform strategies.

6. Support the formation of a Human Resources Development Plan emphasizing training. The form, content, and evaluation of this training should be in accordance with the reform, modernization, and decentralization processes. The plan should also be based on a permanent analysis of performance of the new roles assigned within all the MOH's technical and administrative levels.

7. Continue to follow and stimulate CIAR activities that will foster joint coordination of efforts and that have already succeeded in integrating other donors.

8. The high maternal and infant mortality rates in Ecuador reflect the need to establish national-level policies and goals emphasizing health care promotion. In this regard, USAID assistance could be even more focused on reproductive health, child growth monitoring, and monitoring and surveillance of prevalent childhood diseases.

Provincial Level

9. Support the establishment and institutionalization of provincial health committees based on political agreements and defined responsibilities.

10. Encourage the MOH to define mechanisms for developing a strategic health plan for every province through the broadest-based participation possible and where adaptation of the reform policies would be prioritized within the political and social context. Similarly, epidemiological analysis is necessary to improve the equity, quality, and efficiency of health services, taking advantage of the results already obtained by IMCI, RPM, and NGOs.

11. Given the different cultural environments of the Sierra and Coast regions, positive experiences can be extracted from the provincial initiatives of important institutions, such as the *Junta de Beneficencia* in Guayas, with its long-term self-sufficiency, and the Fundación Pablo Jaramillo in Cuenca, and the analytical capacity generated by USAID. Additional models could be sponsored that include the same elements of collective support and strategic alliances that permit broad-based participation of civil society in the process.

12. Demographic and cultural realities show that special strategies are needed in provinces with extremely poor ethnic groups, especially those with indigenous populations that constitute a high percentage of the Ecuadorian population. Consequently, technical assistance to assess these groups' anthropological and social realities must be a priority. Throughout its experience in developing child survival projects in Ecuador, USAID has considered these facts and could therefore contribute to designing programs more in accordance with Ecuador's reality.

13. A very important contribution during this reform period will be continued USAID support to the MOH, especially through direct technical consulting services to facilitate dialogue. Until a new government is installed, it would also be possible to continue providing training in support of the reform process, both at the MOH internal level and to other public and private institutions. This training could be on basic topics such as executive management, provincial-level administration and management, local-level operational management, management of quality, and communication and social marketing.

7. USAID'S ROLE

7.1 Introduction

The CS project's management team includes a TAACS (Technical Advisors in AIDS and Child Survival) Advisor as project manager (starting in January 1995 at the same time as the newly amended project), a project assistant with 11 years of experience in USAID health and child survival programs, and a secretary who is shared with other projects in the Family Planning, Health and Child Survival Division. This team is supervised by USAID's Director of Multi-Sectorial Programs, who is responsible for activities in health, population, child survival, and democracy.

7.2 USAID's Role

7.2.1 Leveraging and Coordinating Donor Support for MCH Services

The CS management team is held in high regard by other bilateral and multilateral donors who support public and private health sector activities in Ecuador. This group of donors is well informed and well coordinated (with assistance from PAHO) and respects USAID's long-term experience in health and recent interventions (through Phase 2) to promote health reform more systematically and directly. Respondents agreed that USAID/E has made a significant contribution in leadership and investment in the health sector and that this role must be continued by someone when USAID/E terminates its support to health reform activities.

Opinions vary among these donors with regard to the direct impact that will be felt on their organization once USAID/E withdraws from the health sector. Some believe that USAID/E's departure from health will provoke other donors to do the same and that momentum for health reform will be greatly compromised. Others have a more limited view of the entire picture and project that their organizations will continue to support health activities into the indefinite future even if they do not have the mandate to fill USAID's role. Some see health reform in terms of relative financial support, not complementary roles of individual donors. Therefore, they believe that the World Bank's two projects, FASBASE and MODERSA, which are funded at levels many times greater than all other donors in health combined, will continue for the next 5 to 10 years as the key international support to health reform.

In response to the requirement to raise matching funds, CARE has been successful in leveraging USAID's grant for APOLO to a great degree. The Government of the Netherlands recently approved a $750,000 grant over three years for CARE to develop new water supply and sanitation systems throughout the cantón of Chordeleg. This new funding will complement APOLO's health activities. Since the 1980s, the Dutch government has supported CARE's water supply and sanitation activities in Ecuador and considers CARE an experienced and professional development partner.

In addition, CARE has attracted considerable support from the Ecuadorian-Canadian Fund for Development (*Fundo Ecuadoriano Canadiense de Desarrollo* [FECD]) for three of APOLO's demonstration projects. These projects—located in Santa Elena, Bolívar, and Lago Agrio—will receive a total of $776,000 support over three years. Prior to this grant to APOLO, FECD had never supported any health interventions in Ecuador. To date, FECD is pleased with the results, especially those in improving access to health services that involve local communities in the interventions and that promote public-private partnerships for health care.

7.2.2 Efforts to Assure Sustainability of CEPAR (PAPPS) and CARE (APOLO) Components

For both CEPAR and CARE, sustainability can focus on three elements: (1) the benefit of their efforts, such as an active provincial NGO forum in Azuay or new pediatric services in CEMOPLAF; (2) the project (PAPPS and APOLO); or (3) the institution (CEPAR and CARE). To date, USAID's assistance has focused on supporting CEPAR and CARE as institutions so that they can implement PAPPS and APOLO. This assistance is a prerequisite for eventually achieving the shared goals of Phase 2. Both CARE and CEPAR have already shown their organizational ability to continue some elements of Phase 2 beyond the project's completion date.

For example, the APOLO project has attracted other donors (FECD and the Dutch government) who are particularly interested in the private sector approach to improving health services. Both of these donors expressed their interest in continuing to support APOLO's positive results and the potential replications within the context of their organization's respective mandates. Through its participation in Phase 2, CEPAR has already gained significant exposure among international organizations and potential donors.

7.2.3 Development of Strong Relationships with Partners and Clients of Public and Private Institutions

During the first two years of Phase 2, the USAID team invested an enormous amount of time in dialogue with other donors and public and private organizations to gather support for health reform in general and Phase 2 in particular. These activities were focused on CONASA and its working group and the CIAR, because these two organizations comprised representatives of all the key health sector participants. It is largely because of these efforts (in some cases almost daily meetings) that PAHO, UNICEF, MODERSA, FECD, the Dutch government, former Minister Palacio, and others commented so favorably on USAID's role in reform.

7.2.4 Project Management

Re-engineering

Worldwide, USAID is undergoing radical changes (re-engineering) that have greatly reduced the agency's global scope and shifted it from Latin America to Africa and the New Independent States. A decade ago, USAID/E supported activities in health, child survival, water and

sanitation, nutrition, and population with a staff of 12 to 16 people. Now, USAID has only three full-time health professionals on the SO 2 team, two of whom work with Phase 2.

The re-engineering process has required missions to reformulate their projects into a Results-oriented Framework. Of necessity, USAID/E has invested considerable time in complying with this new framework. In the process, the CS team has had to change their SO 2 chart of Intermediate Results and indicators at least 10 times at the request of other USAID colleagues or contractors. Furthermore, the installation of USAID's New Management System and its subsequent withdrawal worldwide required an enormous investment of time by the CS team, with absolutely no benefit. When compliance with USAID/W is the first priority, then time available for direct project monitoring and field visits is even more limited than normal.

Project Executive Committee

The Phase 2 project design called for creating a Project Executive Committee, comprising representatives of USAID and the three major components—the MOH, CEPAR, and CARE. This committee's role was to share information, address mutual problems, and reinforce the understanding of how each component relates to the whole. The committee met regularly, rotating the venue, and functioned fairly effectively from 1995 until August 1996, when the government of President Bucarám took office. At that time, it was the MOH's turn to call the meeting, but given the turmoil, no one in the MOH called the meeting and the committee ceased to function. At the time of the midterm evaluation, most members of the committee expressed interest in reviving it as an important mechanism for addressing the evaluations' recommendations.

7.2.5 Other USAID Projects: Coordination for Mutual Strengthening and Efficient Use of Resources

Table 5 shows the extent of the relationships that APOLO and CEPAR have with other USAID projects for the purposes of promoting (1) mutual strengthening and (2) the efficient use of resources.

Table 5

The Effect of the Relationships between USAID Projects and APOLO and CEPAR on Mutual Strengthening and Efficient Use of Resources

Child Survival	Centrally-funded USAID Projects in Ecuador				
	QA	RPM	OMNI	PHR	BASICS
APOLO	Neither*; Problems with relationship	Neither	Neither	N/A	Yes, but could be better
PAPPS	N/A	Yes Yes (Imbabura)	N/A	Yes Yes	N/A

*Neither=APOLO's relationship with QA does not promote 1) mutual strengthening nor 2) efficient use of resources

With the exception of the IMCI project managed by BASICS, APOLO does not have mutually supportive relationships with centrally-funded USAID projects and is therefore missing opportunities to take advantage of the expertise and resources they offer. For the most part, APOLO has called on independent consultants to provide technical assistance. In contrast, where applicable, CEPAR does work with the projects.

7.3 USAID/Ecuador's Strategic Objectives

7.3.1 Realistic Strategic Objective Goals and Objectives, Especially with Regard to Sustainability of Partner NGOs

USAID re-engineering has also turned projects into "activities" and designs no longer include the well-known Logical Framework. The majority of the indicators for the current SO Framework for Phase 2 are expressed as quantifiable outputs as in the former Logical Framework construct. The exception is *IR3-3,* which is coverage of health facilities with IMCI-trained personnel. The current SO indicators appear to be simplified to make the system manageable for USAID/E. For the most part, these indicators do not reflect changes in important parameters from point A (1995) to point B (end of project). Nevertheless, despite the somewhat scattered collection of IRs, Phase 2 is producing a substantial body of concrete, viable, and useful results.

7.3.2 Project Contribution to Accomplishing Results as Planned in the SO Framework

The Sum of the Components

Following is a summary by component of the contributions to date to Phase 2's *two Intermediate Results, Improved quality and access of MCH services, and increased sustainability of health NGOs*.

APOLO: In a very short time, APOLO has carefully selected partner organizations and implemented a variety of activities with these organizations to improve the quality, equity, access, coverage, and cost recovery of health services. Not unexpectedly, the results have been varied. APOLO is now poised to reflect on its results, articulate lessons learned, and consolidate its approach into one model with a menu of options.

CEPAR: According to evaluation respondents, CEPAR is recognized as the NGO leader in health reform in Ecuador, often acting as a buffer between the MOH and all other stakeholders. Through its technical competency, innovative approaches, and dedication, CEPAR has created a place for itself at a very high level in this national debate. To quote a member of one of the NGO Forums CEPAR has helped to organize: "If CEPAR didn't have the financing [from USAID], they wouldn't have this visibility and clout. And, if they didn't have the clout, we wouldn't be having these results [in moving the reform process forward]."

MOH: The major results accomplished by the MOH in Phase 2 are a combination of those activities directly supported by CEPAR and those supported by other USAID/E projects, such as BASICS. The MOH's own ability to take advantage of USAID's CS resources was severely compromised in the first half of Phase 2. Nevertheless, the current MOH counterpart for Phase 2 has shown interest in and capacity for working collaboratively with USAID. After one year's delay, the MOH's very recent production of a short-term Phase 2 budget and action plan is a positive sign.

Synergy Equals More than the Sum of the Components

The Phase 2 design implies a symbiosis among the three project components that, for many reasons, is not reflected in the results to date. Current relationships among the three partners are reflected in a triangular design (see Appendix D). If each pair of components acted synergistically, Phase 2 results would be dramatically increased. As indicated in the following examples, the potential exists; the key players—USAID, CARE, CEPAR, and the MOH— are capable; the need is real; and the climate is supportive through activities already undertaken during the first half of Phase 2.

- **APOLO-PAPPS Relationship**: Not functioning adequately due in large part to feelings of competition and misunderstandings about the other's actual activities

and motives. PAPPS should use APOLO's results and similarly, APOLO needs PAPPS to help it grow and replicate.

- **PAPPS-MOH Relationship**: Functioning as well as MOH constraints allow. PAPPS implements many of its activities through the MOH and thus serves as a mechanism for changes that are to be manifested by others. This should continue.

- **MOH-APOLO Relationship**: Not functioning adequately. APOLO and the MOH could benefit from a more symbiotic relationship. Currently, these two components have specific areas of conflict and a somewhat generalized feeling of disrespect. At this point, APOLO and the MOH are operating almost independently in the field and the individuals involved do not benefit from the potential available to them if they acted synergistically.

7.4 Impact of USAID/Ecuador's Termination of Health Sector Support in Ecuador

USAID/E is in an overall phaseout mode; support for health is now scheduled for termination in September 2000, several years before the rest of the mission's other activities. Considering the fact that Phase 2 represents a totally new approach to improving the quality, access, coverage, and sustainability of MCH and CS services, a six-year period (1995 to 2000) may not be sufficient to achieve the proposed results. If USAID/E can promote synergy among the three components of Phase 2 and accelerate this process throughout the remainder of the project, great strides could be made in health reform.

On the other hand, the 1998 government elections and resulting changes in the MOH could stifle current initiatives. When Phase 2 started in 1995, the design had the potential for additional phases beyond Amendment 8. Now that the completion of Amendment 8 will also signal the termination of USAID/E's health sector assistance, all players need to adjust their plans, expectations, and strategies accordingly. The time remaining in Phase 2 (less than three years) is not merely the second half of Amendment 8, it is also USAID's final opportunity to leave sustainable systems in place to continue the health reform process. In working in Ecuador's family planning sector, USAID/E has successfully nurtured two local organizations to continue as sustainable entities after USAID/E assistance ceases. This process has taken approximately two decades; thus, any extension of the CS project beyond September 2000 will add crucial maturation time to the innovative activities initiated in 1995.

7.5 Conclusions

7.5.1 Role of USAID in Health Sector Reform and Potential Impact of Termination of USAID Development Assistance in Health

Although health sector reform is officially underway in Ecuador, the general opinion appears to be "since it's such a monster, let others do it." USAID/E has faced this challenge head on, and risked taking the plunge into health sector reform while the majority of other participants have stayed on the sidelines. Ecuadorian leaders and members of the wider international development community devoted to health sector reform recognize the results as significant, innovative, and concrete. To quote one interviewee, "Amendment 8 dynamized the reform process."

USAID's decision to leave Ecuador coincides with a period of heightened expectation regarding reform, not only in the health sector. As of August 1998, a new government will take over and will have a new constitution to implement. Given the positive opportunities this scenario presents, it would be helpful if the CS project had another five years to work with this new structure. A supportive minister of health and well-chosen subordinates could command enough political strength to move forward with reform. USAID has already promoted reform on a number of fronts. Those directly related to the MOH are now mostly "on standby" with the interim government, while those being implemented by NGOs are forging ahead. If USAID's accomplishments to date are combined with a supportive MOH, health reform could even move faster and further than otherwise expected.

7.5.2 Sustainability of CEPAR (PAPPS) and CARE (APOLO)

Both CEPAR and CARE have gained considerable expertise, credibility, and visibility from their involvement in Phase 2. Indeed, this project has helped CEPAR become one of the leading NGOs in Ecuador in health reform, which is quite an accomplishment since prior to 1995 CEPAR had restricted its efforts to the family planning arena.

In Ecuador, the reform process needs to be able to continue with support from a wide variety of participants, regardless of the presence or absence of CEPAR and CARE and their respective components. Therefore, the focus of USAID's assistance should be on the first element of sustainability, to increase the probability of self-perpetuating activities in policy reform and continued development and replication of public-private partnerships for the delivery of MCH services. Neither the components themselves nor the institutions that implement them are appropriate sustainability goals of Phase 2. One of USAID/E's challenges is to develop sustainability indicators with CEPAR and APOLO that distinguish among the benefit, project, and institutional aspects of sustainability for Phase 2's desired end-of-project status.

7.5.3 Relationships with Other Development Partners

The majority of information reaching USAID about CEPAR and APOLO's relationships with other institutions appears to come directly through representatives of these two projects. Therefore, the information is subject to filtering that can diminish evidence concerning potential problem areas.

7.5.4 Project Management

An activity as large, complex, and important as CS needs USAID to devote more direct attention to its implementing partners. At this point, the partners will need assistance in processing, implementing, and monitoring the midterm recommendations. The demise of the Project Executive Committee has led to decreased communications among Phase 2's critical components and a loss of mutual esprit de corps, respect, and potential for effective collaboration.

7.5.5 Other USAID Projects

The five centrally-funded projects cofinanced by Phase 2 can continue to support the overall benefits of Phase 2 beyond its projected termination date of October 2000, assuming that the projects continue themselves and can justify support for Ecuador. This mechanism would provide critical follow-up and necessary technical assistance and resources when USAID/E is no longer able to do so.

7.5.6 USAID/Ecuador's Strategic Objectives

Design Weaknesses

The lack of a Logical Framework for Phase 2 or a reasonable substitute that shows "if this, then that" with indicators at different levels, may be partially responsible for some of the weak structural relationships among the major project components. Presumably, CARE and CEPAR are monitoring additional sets of indicators that are more reflective of the actual changes sought and the impact desired than the SO2 indicators.

The SO Framework has introduced difficulties in expressing the expected results of Phase 2's activities in their appropriate terms, i.e., in terms of a process. The real value of Phase 2 is not in its success per se—that is, achieving the nine Intermediate Results as stated in the SO Framework—but in its ability to effect reform and be replicable regardless of the future of

APOLO, PAPPS, CARE, and CEPAR. The emphasis should be on sustaining benefits, not NGOs. This conclusion is a natural outcome of the comments made in Chapter 4.2.2 on the elements of sustainability.

Need for Synergy

The real potential of USAID's CS project will not be reached unless and until the individuals responsible for the three project components understand and accept the roles of their respective organization as members of a single CS team. Both APOLO and PAPPS need to do fewer activities, do them well, and do them as part of a coherent whole.

Although the CS project enjoys considerable support within USAID/E, USAID could use its political weight to a greater degree to accomplish the proposed SO results in health reform. USAID has access to institutions and persons to which CEPAR and CARE do not. For example, CEPAR cannot change policies alone and risks a negative reaction if it takes too high a profile.

7.6 Recommendations

USAID's Role in Health Sector Reform

1. Since Phase 2 represents a "new project" in design and approach, it needs to be able to adapt to the reality of USAID/E phaseout by planning its own phaseout to coincide with the mission's phaseout. USAID/E should reconsider the decision to terminate the CS project at the end of FY 2000, and preferably extend support for health as long as USAID/E is in Ecuador.

2. The CS project should be protected from any downsizing with USAID/E, given its short life to date and its need for more intensive USAID contact with implementing partners.

Sustainability of Benefits

3. USAID should focus its efforts on modifying PAPPS and APOLO according to the recommendations from this evaluation so that the results, or benefits, can be sustained beyond the project completion date.

Project Management

Overall

4. If Phase 2 is to reach its true potential with the time and resources available to USAID/E, the USAID management team needs to become substantially involved to take charge of the evaluation recommendations, make midcourse corrections within USAID and externally with APOLO and PAPPS, and closely monitor outcomes.

Promoting Synergy

5. USAID should rebuild the Child Survival team. USAID should reinstate the Project Executive Committee and hold all meetings at USAID in the foreseeable future.

6. As project manager, USAID must take increased responsibility to work with representatives of the three components, and other USAID projects involved, to develop an integrated vision of the project and instill a team approach. In the context of implementing midcourse corrections, possible steps to address this goal include implementing the following:

   (a) Carefully-structured sessions between selected key participants—between CARE and CEPAR, and between the MOH and CARE—to identify and address current feelings of disrespect, anger, and competition.

   (b) A team-building and consensus-building exercise among Phase 2 implementers designed to (1) articulate reasons for working together, (2) identify areas of consensus, (3) understand how the components should work together, and (4) develop specific activities and indicators for moving forward. This exercise should include constructing an integrated project design diagram, including indicators, and should include the supervisors of the coordinators of each component.

   (c) Initially, weekly meetings between USAID and key decision makers within APOLO, PAPPS, and other specified team members to develop specific plans, indicators, and dates for implementing evaluation recommendations. These indicators should not only reflect the end of the Phase 2 project, but should reflect the fact that USAID/E is in a phaseout mode. Once these new plans are approved, they should be included in the amended Cooperative Agreements.

   (d) APOLO and PAPPS could consider using some of PAPPS's consensus-building techniques to help resolve the conflict with the MOH in Chordeleg and promote an integrated approach to health services in the larger health

area of Gualaceo.

(e) PAPPS could use some of APOLO's techniques to develop communications materials for varied audiences.

7. CARE and CEPAR should help direct USAID to key issues where USAID high-level intervention can help build consensus and thus accelerate the reform process. CEPAR should assume a lower profile and allow USAID to make more timely interventions in the policy process. For example, USAID could have a direct line to CONAM.

Communications and Monitoring

8. USAID should have more frequent contact with the APOLO and PAPPS coordinators and additional contact with other members of their respective teams. Maintaining this frequent contact might require additional personnel if the responsibilities and workloads of the current USAID team do not allow them to adjust accordingly.

9. USAID should become more directly involved in monitoring CEPAR and APOLO's activities in the field and from the perspective of their collaborators and clients.

Build Ties for the Future

10. Phase 2's activities can identify and give special support to those members of the MOH who are currently providing excellent collaboration, in areas such as IMCI, to prepare them for the eventual withdrawal of bilateral USAID funding.

11. Members of the evaluation team should be formally authorized by USAID/E to proactively promote the CS project, its current achievements, and its potential to key decision makers in QA, PHR, RPM, BASICS, and OMNI.

Pay Special Attention to APOLO

12. Work with APOLO to identify mutually beneficial opportunities to collaborate with other USAID projects. For example, OMNI is preparing to undertake operations research in iron supplementation of pregnant women. APOLO could facilitate discussions between OMNI and CEMOPLAF (Otavalo or Lago Agrio) for these activities.

APPENDICES

APPENDIX A

Scope of Work

EVALUATION OF HEALTH AND CHILD SURVIVAL ACTIVITY 518-0071

BACKGROUND:

USAID/Ecuador plans to carry out an external evaluation of the Child Survival and Health Activity 518-0071, presently scheduled to end on May 31, 1999. If this evaluation supports a continued effort beyond this date, we are planning to extend the activity/results package through FY 2000. This activity is included under the maternal child health services' results package which is part of the Mission's Strategic Objective # 2. The activity consists of three components: (1) Ministry of Health (MOH) Policy Reform under a bilateral agreement with the Government of Ecuador. This component supports the formulation and implementation of health sector reforms and modernization actions. The total funding for this activity is $9,833,769; (2) Analysis and Policy Promotion under a Cooperative Agreement with a local Non-Governmental Organization, Centro de Estudios de Poblacion y Paternidad Responsable (CEPAR). The funding level for this agreement is $2,000.000; and (3) Private Sector Program Strengthening under a Cooperative Agreement with CARE, an international Private Voluntary Organization. Under this component, CARE is expected to develop innovative demonstration projects. The total funding level is $3,400,000.

The purpose of the activity is to improve the effectiveness of Child Survival and primary health care programs and interventions nationwide with a focus on the poor in rural areas and peri-urban communities. This would be accomplished through reform of the health sector, modernization of the MOH, and development of innovative, sustainable demonstration projects.

ARTICLE I - TITLE

Activity: Health and Child Survival, Number: 518-0071

ARTICLE II - OBJECTIVE

A four person team for a period not to exceed 25 work days each is required to review the progress of the USAID-sponsored Child Survival and Health Activity, No. 518-0071, and make recommendations for the remainder of the activity. The USAID Mission in Ecuador intends to utilize the evaluation results to make adjustments (if necessary) in the administration of the specific activities planned for the final two (or three) years.

Each element should be evaluated in terms of whether the strategic objective results/indicators will be met in a timely and effective manner identifying specific internal/external constraints which can limit the strategic objective success.

ARTICLE III - STATEMENT OF WORK

A. **Activity components:** Evaluate specific activity implementation elements including (1) modernization/reform of the MOH; (2) analysis and promotion of health policy reforms; (3) development/implementation of innovative demonstration projects; (4) development of local capabilities to provide services and participate in health reform activities.

B. **Activity Management:** Evaluate the adequacy and effectiveness of activity management and administration on the part of the Ministry of Health, CEPAR, and CARE. In the case of the MOH, this should focus on the MOH's capability to execute activities given the high degree of turnover at top levels of the MOH (officials with whom we work closely including our primary counterpart), and the large number of strikes that close down the Ministry every year. With regard to CEPAR and CARE, the focus should be on overall components management, meeting deadlines, monitoring, coordination with other donors and projects, and use of technical assistance.

C. **USAID Role:** Examine the effectiveness of USAID support, monitoring, management of three components including identification of constraints. Special emphasis should be put on evaluating USAID's role in (1) donor coordination and in organizing and coordinating donor support for maternal child health services activities; (2) efforts to assure sustainability of CEPAR and CARE components; (3) development of strong relationships with partners and clients of public and private institutions, e.g. MOH, Social Security (IESS), Peasant Social Security (SSC), National Health Council (CONASA) NGO's, etc.

D. **Technical Assistance/Field Support Activities:** Although Field Support activities conducted by the Quality Assurance (QA) Project; Opportunities for Micronutrient Interventions Project (OMNI); Basic Support for institutionalizing Child Survival (BASICS); Partnerships for Health Reform (PHR) and Rational Pharmaceutical Management (RPM) are not part of the bilateral agreement with the GOE nor part of this evaluation, they are critical elements in the modernization component with the MOH and for support to CEPAR and CARE.

E. **Key Questions to be answered**: The evaluation team should place special emphasis on answering the following questions and making recommendations as to how USAID can improve and/or strengthen the activity to increase the likelihood of achieving objectives/results as defined in these questions.

A. Project Management by all components:

1. Is project management structure functioning adequately? e.g. Component Implementation Committees; Overall Executive Committees, etc.
2. Has USAID/E's effort to win the support of other donors for activities been successful?
3. Have different USAID/E activities/projects been adequately coordinated resulting in mutual strengthening and more effective use of resources?

B. MOH Modernization and health reform:

Has the activity had an impact (or is it likely to) on:

1. targeting public sector resources on the needs of the poor;
2. improved allocation of resources for preventive care;
3. improvement in the definition and coordination of roles/functions of health sector institutions, i.e. MOH focus on planning, establishing policies and norms, assuring quality, supervision, evaluation, etc;
4. decentralization of health services;
5. implementation of cost-recovery policies;
6. How can the Non-Governmental Coordination Office at the MOH be strengthened?
7. How successful is the ESPOL graduate program in health care administration? Is the program sustainable? Does it have adequate support in the public and private sectors?

C. Analysis and promotion (especially CEPAR component):

Has the activity had an impact (or is it likely to) on:

1. strengthening of the NGOs in order to improve their institutional sustainability over the long-run.
2. improving local capacity to participate in health reform related activities;
3. expansion/improvement of the capability/role of the private sector (NGO's) and municipalities as service providers;
4. Has CEPAR been successful in its effort to promote health reform?
5. What is the usefulness and quality of studies developed by CEPAR?

D. Field Demonstrations (especially CARE/APOLO activities):

Has the activity had an impact (or is it likely to) on:

1. decentralization of health services;
2. expansion/improvement of the capability/role of the private sector (NGO's) and municipalities as service providers;
3. improving local capacity to participate in health reform related activities;
4. What is the usefulness and quality of management tools developed by CARE?
5. Can we expect the CARE/APOLO demonstration projects to show measurable results by the PACD? Are the CARE/APOLO objectives feasible? Will the sub-projects reach their sustainability goals? Are the projects replicable?

E. Overall accomplishment of results and S.O.

Has the activity had an impact (or is it likely to) on:

1. targeting public sector resources on the needs of the poor;
2. strengthening of the NGOs in order to improve their institutional sustainability over the long-run.
3. implementation of cost-recovery policies;
4. Are the SO goals and objectives realistic, especially with regard to sustainability of partner NGO's?;
5. Is the project contributing to accomplishing results as planned in the SO framework?
6. Has training done by CEPAR and CARE had the desired impact?

F. **Recommendations:** Discuss specific recommendations regarding the implementation of the activity/results package in order to assess and/or maximize its processes and impact. The team should review the indicators that are currently being utilized by the results package and USAID, as evaluation recommendations will facilitate USAID monitoring and evaluation. Provide specific recommendations on how the activity/results package might be revised/adapted to improve the likelihood of accomplishing planned results/objectives.

ARTICLE IV - REPORTS

A summary of the team's report, including an outline of full report, major findings, lessons learned, conclusions and recommendations must be completed in English and Spanish and reviewed with USAID, MOH, CEPAR and CARE prior to teams departure from Ecuador. This summary must be presented at least two days before the debriefing date. This debriefing will take place at USAID and will involve key senior staff of the Mission.

A draft of the full report should be received by USAID within three weeks after the team leaves the country. The final report, incorporating USAID and partners comments should be presented to USAID within 30 days after receipt of Mission comments on the draft report. A total of ten copies will be required and also a report on diskette WP 5.1.

ARTICLE V - RESPONSIBILITIES

Contractor is responsible for an initial two to three days team planning and orientation meetings, to be held in Quito, which will orient the evaluation team, clarify roles, redefine evaluation questions, and establish a detailed workplan, including a schedule for field visits. During these meetings contractor will meet with key staff from the USAID, MOH, CEPAR and CARE. Contractor's responsibility will include travel to activity/results package sites and all related arrangements, e.g. logistics, local secretarial assistance, etc.

USAID/E will arrange for the participation of key local partners, and can assist the contractor in identifying local personnel for facilitator, secretarial support, a driver and vehicle.

Contractor is also responsible for nominating a team leader in charge of the coordination and of integrating the final report.

ARTICLE VI - PERFORMANCE PERIOD

The evaluation should begin o/a October 15, 1997. All four technical specialists should plan to be in Ecuador for a minimum three full work weeks of six days. The team leader may need a few additional days in-country for post field work follow up after Mission debriefing. All members are authorized up to five days of effort each for pre-visit review of documents, meetings with USAID Washington, and post-visit final drafting of report.

ARTICLE VII - WORK DAYS ORDERED

Position:	Max. work days
Project/Health Management Specialist	25
Health Economist/Finance Specialist	25
Maternal Child Health/Health Services Delivery Specialist	25
Evaluation Specialist/Policy Reform Expert	25
	100

(One of the specialists should be an MD and all should have a Masters Degree or equivalent.)

ARTICLE VIII - ILLUSTRATIVE EVALUATION TIMEFRAME

Activity	Work days	Place
- Pre-departure document review	2	Washington/US
- Task planning meetings and information review interviews in Quito	8	Quito
- Field Visits	8	6/7 provinces
- Follow-up meetings	2	Quito
- Draft report writing in-country	2	Quito
- Debriefing	1	Quito
- Final report writing	2	U.S.
	25	

ARTICLE IX - USAID ILLUSTRATIVE BUDGET

See Attachment A

ARTICLE X - SPECIAL PROVISIONS

A. Duty Post: The duty post will be Quito. Visits to different provinces will be necessary.

B. Language requirements: Spanish: Speaking 4, Reading 4

C. Experience: field experience in Latin America health sector is required. Ecuador specific experience strongly desirable.

D. Access to Classified Information: Contractor will not have access to any government classified material.

E. Logistic Support: The team should come prepared to arrange and pay for all necessary logistical support, including typing and translating.

F. A six day work week is authorized.

APPENDIX B

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APPENDIX C

List of Contacts

Ecuador

Acosta, Mario. OMNI Representative, USAID/E, Quito.

Acurio, David. SENDAS y Coordinador del Foro de ONGs de Azuay, Cuenca, Azuay.

Aguilar, Marcelo. Director General de Salud. Ministerio de Salud. Quito.

Aguilar, Marcelo. Medical Subdirector, Fundación Humanitaria Pablo Jaramillo Crespo, Cuenca.

Almeida, Miguel. Asesor del Ministro de Salud, Quito.

Andrade, Fausto. Director de FASBASE.

Arias, Claudio. Provincial Director of Health of Azuay, Cuenca.

Armas, Washington. Director de la Escuela de Postgrado en Administración de Empresas de la Escuela Superior Politecnica del Litoral.

Astorga, Alfredo. Oficial de Proyectos. Fondo Ecuatoriano Canadiense de Desarrollo, Quito.

Barragán, Guillermo. Cost-effectiveness consultant, PAPPS, CEPAR, Quito.

Barros, Flavio. Mayor, Municipality of Chordeleg, Azuay; and eight members of the Municipal Health Committee.

Bernabe R., Sandra. Administradora, Clinica Cristo Redentor, Santa Elena, Guayas.

Brito, Mariana. Administrator, Fundación Humanitaria Pablo Jaramillo Crespo, Cuenca.

Buitrón, Myriam. Consultant, PAPPS, CEPAR, Canton Cotacachi, Imbabura.

Butiña, Maria Elena. Directora de Higiene Municipal, Municipio de Ibarra, Imbabura.

Candell Soto, Jimmy. Alcalde de Santa Elena, Guayas.

Castrillón, Jaime. APOLO. Quito.

Cervantes, Lilian, Director of CEMOPLAF Clinic in Otavalo.

Chavez, Aida Haro. Presidenta, CEMOFLAF, Quito.

Coronado, Susana. Contadora, CEMOPLAF Clinic in Otavalo.

de Crespo, Juana Catalina Jaramillo. Director, Fundación Humanitaria Pablo Jaramillo Crespo, Cuenca.

Crespo, Marcelo Jaramillo. Member of the Board of Directors, Fundación Humanitaria Pablo Jaramillo Crespo, Cuenca.

Dancose, Jean. Director Canadiense, Fondo Ecuatoriano Canadiense de Desarrollo, Quito.

Duenas, Susana. Pediatrician, CEMOFLAF Clinic, Otavalo, Imbabura.

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Echeverria, Ramiro. MODERSA. Quito.

Egas, José María. Director de Desarrollo Social, Municipio de Cuenca, Cuenca, Azuay.

Encalada, Danilo. Jefe de Area de Salud de Gualaceo, Azuay.

Espinosa, Patricio. Former Director of CONASA, Quito.

Farr, Kenneth. Director of General Development Office, USAID/E, Quito.

de Figueroa, Miriam Reyes. Representative, UNICEF, Quito.

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Galloway, Jack. Project Officer, Office of Multisectorial Programs, USAID/E, Quito.

Garcia, Fernando. Gerente de Proyectos, Fondo Ecuatoriano Canadiense de Desarrollo, Quito.

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Geiger, Thomas. Director, USAID/E, Quito.

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Hevia, Patricio. Representante de OPS/OMS para el Ecuador.

Huerta, Francisco. Subdirector, Fundación Eugenia Espejo, Quito.
Ex-Ministro de Salud.

Jaramillo, Milton. Jefe, Fortalecimiento de la Red de Servicio, Dirección Provincial de Salud, Imbabura.

Kaelin, Ursula. Dispensario de Bajada de Colonche, Santa Elena, Guayas.

Kastillo, Oscar. Doctor, Hospital Cotacachi, Imbabura.

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Lopez Cumenda. Auxiliary Nurse, Sub-Centro de Salud Chordeleg.

Lucio, Ruth. Health Economist, PAPPS, CEPAR.

Malo, Miguel. Escuela de Medicina, Universidad Catolica, (member of Public Health Schools Network), Quito.

Marangoni, Pablo. Director de la Junta de Beneficencia de Guayaquil y Director de APROFE, Guayaquil.

MacGillivray, Leo. Director, CARE, Quito.

Martinez, Fernando. APOLO, CARE, Quito.

Merino, Cristina. Epidemiologist, PAPPS, CEPAR, Quito.

Muñoz, Oswaldo. Director de Epidemiologia, Dirección Provincial de Salud, Azuay.

Nelson, David. Representantive of Rational Pharmaceutical Management, USAID, Quito.

Oveido, Nelson. Executive Director, CEPAR, Quito.

Palacios, Alfredo. Ex-Ministro de Salud.

Palacios, Iván. Coordinator, APOLO, CARE, Quito.

Piedra, Alicia. Directora de Recursos Humanos, Clínica Pablo Jaramillo, Cuenca.

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Racines, Angel. Director de Planificacion. Ministerio de Salud. Quito.

Redrobán, Hernán. Coordinator of Health Financing, APOLO, CARE, Quito.

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Sacoto, Fernando. Director de MODERSA, Ministerio de Salud. Quito.

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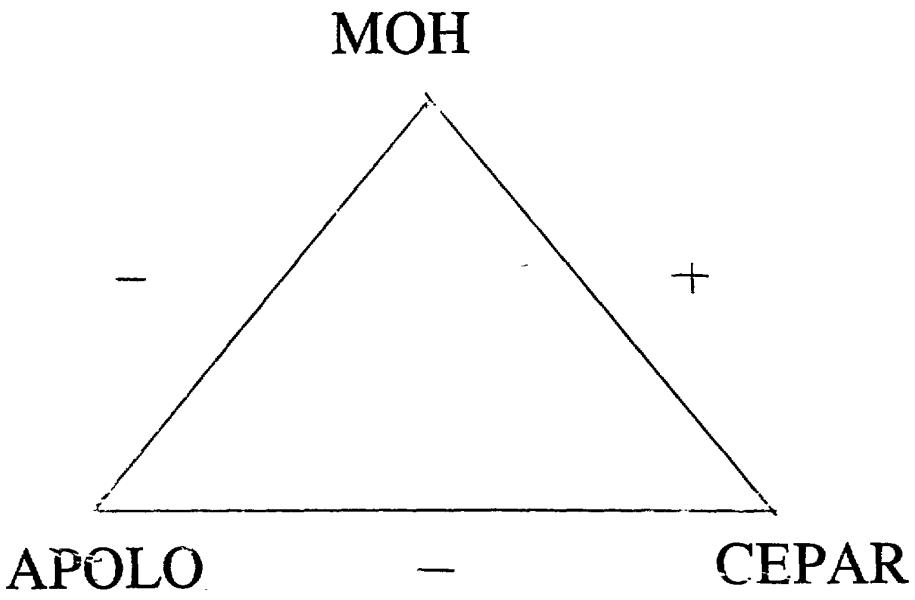
APPENDIX D
RELATIONSHIPS AMONG THE THREE PROJECT COMPONENTS



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